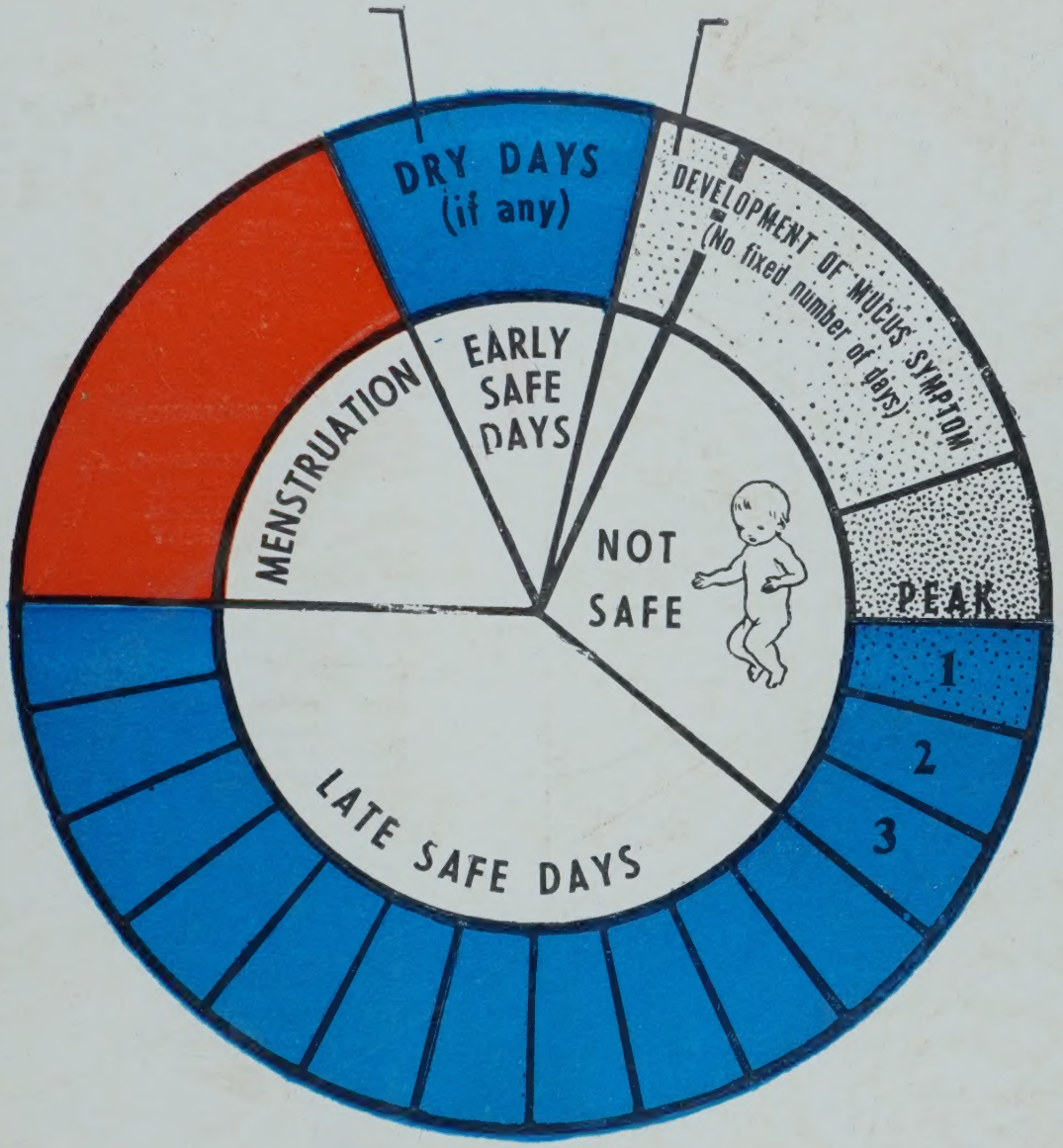
NATURAL FAMILY PLANNING TEACHER



For Nurses and Community Health Workers

by Dr. MARIE MIGNON MASCARENHAS, M.B.B.S. D.P.H. F.R.I.P.H.H.

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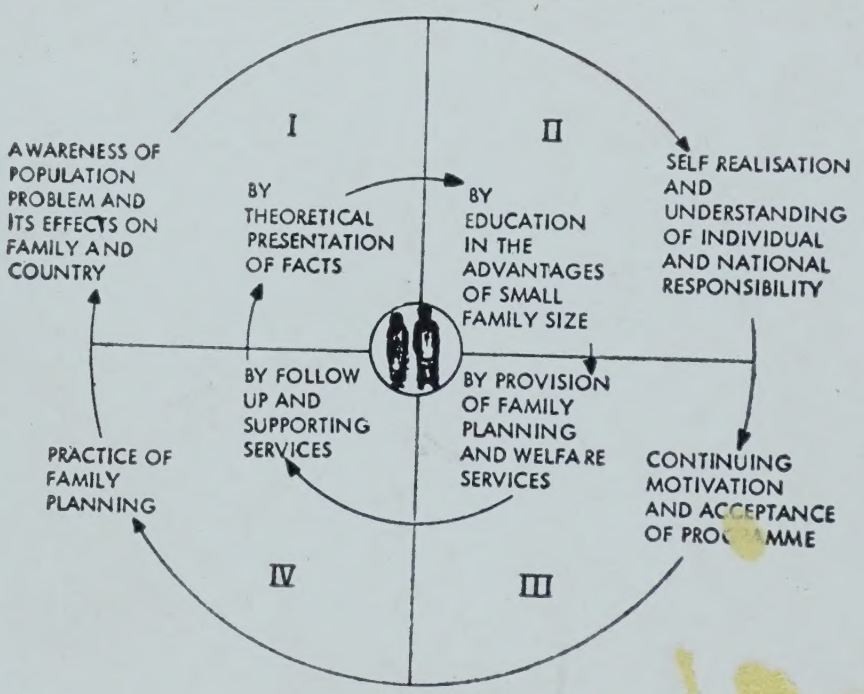
THE CYCLE OF HEALTH EDUCATION FOR FAMILY PLANNING



NATURAL FAMILY PLANNING TEACHER

by

Dr. MARIE MIGNON MASCARENHAS

M.B.B.S., D.P.H., F.R.I.P.H.H.

To Thelma and Rais
from Great and
Marie Mignon Mascarenhas

ASIAN TRADING CORPORATION

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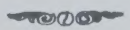
To the Indo-German Social Service Society, New Delhi which made possible the Karnataka Fertility Study.

To the thousands of couples, barefoot teachers, educators, nurses and colleagues whose cooperation has made NFP a practical reality in India.

To Selena Nunes, artist, and to the publishers for their painstaking collaboration.

In a very special way to Mr. F.M. Pais of Asian Trading Corporation, Bangalore.



For worldwide information on NFP write to The I.F.F.L.P. (International Federation for Family Life Promotion) 1511 K. Street, N W. Suite 333, Washington D.C. 20006, U.S.A. and W.O.O.M.B. (World Org. O.M. Billings) 27 Alexandra Plarade, North Fitzroy, Melbourne Vic 3068, Australia & to Crest 14 High Street, Bangalore-560 005.

Author's Note

Nurses and Community health workers play a key role in promoting NFP

Scientific and technological miracles have been achieved in this century yet nothing has surpassed or even equalled nature. In particular, there is no equal to the Natural Family Planning methods as regards safety, wide applicability, reliability, inexpensiveness and dependence on the couple (not on doctors or drugs). In addition they are very effective when used correctly.

Natural Family Planning can be considered a **new concept of health care,** a step in the right direction toward self-help and positive health, reaching out as it were to nature for guidance. No nurse can ignore the vital role that she can play, whether in the hospital ward, outpatient or in the field, in the area of fertility regulation or Family Planning. Moreover, it fosters the establishment of a **"self energized family"**, the aim of health care workers in developing countries. In the West too, many cultures and groups are becoming increasingly interested in natural methods.

In conclusion, our enchantment with modern technology should not lead us to reject the self-control methods that have been culturally acceptable for ages. With all this background there is a great scope for wider use of the **Billings' Ovulation Method** which I am privileged to present in this textbook remembering as I do taht "God forgives always, Man forgives sometimes, Nature forgives never"

Marie Mignon Mascarenhas
MBBS (Bombay) MFCMRCP (Eng.)
DPH (Lond.) FRIPHH (Eng.)
Principal Investigator WHO Study
Member WHO Expert Group for NFP, Geneva
Director, Karnataka State Fertility Study
Member Task Force NFP I.C.M.R. New Delhi,
July 1985.

C R E S T
Centre for Research Education Service & Training for Family Life Promotion
14 High Street, Bangalore-560 005 (India)

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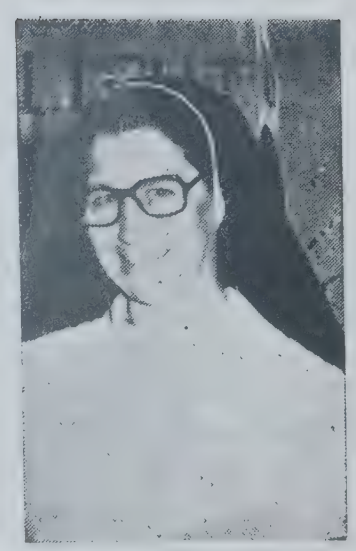
Introduction

RAFAEL SALAS
Executive Director, United Nations Fund for Population Activities, has written :—

"It would be beneficial. . . . ., where an attempt is made to focus both on the role of women and the importance of the family as an institution, to transcend this view and examine the assertion of the World Population Plan of Action that the family is the "basic unit of society". This can underline its role as transmitter and harmonizer of personal and social values for the balanced development of the individual within the communities in which they live. **The family must be looked upon not just as an institution that affects fertility but as an institution that fosters and harmonizes values and makes decisions on the size of the family consonant with the dignity and freedom of the human person."**

Salas, R.M. Reflections on Population. New York : Pergamon Press, 1984.

Foreword



When one considers that the population of India is increasing at the rate of 14 million every year or adding one 'Australia' to its existing people it is evident that to provide for such a growth is a herculean task for any Government. At the same time man/woman is becoming progressively more aware that every human person must be given equal opportunity to live, to learn and to be fully himself/herself. It is necessary that these two extremes be somehow bridged, not in an impersonal, mechanical way, but by man himself taking the initiative and the challenge to decide his own destiny. **"Let us make man....to be the master of all life upon the earth and in the skies and in the seas"** in this sentence the author of Genesis tells us that man has been given dominion over his own life. The mystery of man's existence has always teased the minds of the philosophers and scientists, not less today than in previous ages. The answer to his quest yields itself slowly to painstaking research. Quick solutions to the problems he encounters slow down rather than speed the process of discovery.

This book on the Natural Method of Family Planning is the result of true scientific research, undertaken by a person who believes that **all human life is sacred.** It is written in the spirit of the encyclical Humanae Vitae which tells us that **"procreative finality applies to the totality of married life rather than to each single act".** Serious persons who desire to keep a right order of priorities and recognise their duty towards God, themselves, their families and human society, will find here many of the answers to their questions and the encouragement and guidance to take part in this movement towards man's complete dominion over the earth. This is possible in the measure that he/she has achieved control over the most powerful of all weapons—his/her own passion.

Dr. Marie Mascarenhas has a long association with nurses and therefore it is not surprising that she wishes to address this book specifically to them. Nurses play a vital role in bringing about a healthy society. **Health as defined by the W.H.O. is a state of 'complete physical, mental, social and spiritual wellbeing'. Nursing is no longer restricted to caring for the sick and infirm.** As an influential member of society the nurse is privileged to meet with many hundreds of people in the course of her day to day work in the hospital or clinic. **Her encounter with each one** is often of a much longer duration than that of the doctor, she gets to know her patients more intimately and as part of her caring for them she involves the whole family. This becomes an ideal setting for

teaching. The value system by which the nurse lives can help or hinder the holistic approach to health which today is recognised as essential. This being the case it is understandable that the author wishes that nurses become familiar with the natural method of family planning, for she rightly believes that once nurses and Community Health Workers are convinced, they can get the message across to many families in both village and towns.

Familiarity with a subject is a necessary requisite for good teaching. The teacher should be able to adapt her material to a variety of people with various levels of understanding. This means a thorough study. We should feel encouraged to take this up by the special words which Pope Paul VI addressed to doctors and nurses "**. . it is an essential part of their skill to make themselves fully proficient in this difficult field of medical knowledge**" (H V.No. 27). **The nurse's training and experience in communication and her awareness of the psychological needs of patients will prove to be a great asset in imparting this knowledge. She is also in an advantageous position to follow-up the couples and give encouragement and advice when needed.** Having mastered the technique the nurse herself will be the first to benefit from this integrated knowledge of her being, the interplay of the physiological, psychological and spiritual, so necessary for self-actualisation. As a responsible member of society she will then be enabled to help mankind to get in touch with the deeper dimensions of life while at the same time playing her part in building a better society.

The book needs careful study. It does not present mere cold facts and figures though those are there. It gives a comprehensive view of the importance of family planning in todays society and **tells us why Natural Family Planning is more in keeping with man's true nature than any other mechanical or chemical means.** It provides clear explanations of the physiology of the male and female reproductive system. It shows how both husband and wife are responsible for the success of the method and speaks with authority on the deeper and **more satisfying relationship which develops between couples** as a result of its use.

The book dispels the myth that the Natural Method of Family Planning is impossible for the ordinary persons because of the mistaken idea that it requires long period of abstinence, or that it is too complicated for the illiterate person to understand. As Professor Billings writes in his book "**This method depends on the biological fact that woman is at most times infertile throughout the whole reproductive phase of her life**".

I am sure that this text book for nurses and community health workers will be of immense help in their endeavour to communicate this 'Good News' to couples, and will liberate many families from the fears and tensions which today they have often to endure.

SR. M. BREDA Mc COY, R.G.S.
M.A., S.R.N., R.M., D.N.E.

CHAPTER 1

Fertility Knowledge is Fertility Regulation

Natural Family Planning, (NFP) methods are based on the natural or physiological periods of fertility and infertility in a woman.

The **fertile period** is dependent on the fact that a woman can only conceive when an ovum (or female egg) is present and when it is fertilised by the sperm (or male egg cell).

The ovum is present only once in a menstrual cycle and research studies now show that the ovum remains viable for only 12–16 hours. By 24 hours it dies if not fertilised and degeneration follows rapidly.

Nature has made the woman to be infertile for long periods in her reproductive age (14–44). Hence the average healthy fertile woman has only to know the few fertile days that occur in each monthly cycle in order to regulate her fertility.

If she wishes to have a child it is only on one of these few fertile days that intercourse could result in conception. Alternately, if she wishes to avoid a pregnancy for purposes of delaying her first child, or spacing or limiting the family size, she and her husband have only to avoid sexual contact on these days. **Thus nature herself provides every married couple with an answer to the problem of family planning.** The man, if fertile, has sperms always present is his body. The male sperms (or eggs) however, have a short life span in the female genital tract. Most sperms are dead within a few hours. Even in the presence of fertile mucus they rarely live for more than 2 to 3 days.

Even more specifically Patten says :– "Sperms retain their fertilising power for only 1-2 days, with motility only persisting for perhaps double that time."

With this fact, therefore, of the short life span of both the ovum and sperm, and with an even shorter period of fertilisability and fertilising power respectively, it is left only to develop effective ways for a woman to pinpoint her ovulation, which occurs only once in every menstrual cycle. Double ovulation is very rare and when it occurs, the second ovum is released within 24 hours of the first.

Into existence comes therefore "Natural Family Planning" a relatively new term for achieving or avoiding pregnancy

through the timing of intercourse and a distinct improvement on the calendar rhythm method.

Over the past 15 years, three methods have come to dominate the field of NFP and completely replace the old unscientific calendar Rhythm method.

The three methods are :

(1) The Ovulation Method–O.M.

(2) The Symptothermal Method

(3) The Basal Body Temperature Method.

1) **The Ovulation Method** is one in which the woman learns to recognise the changing cervical mucus pattern which in turn identifies the fertile and infertile periods of the menstrual cycle. The detection and observation of this oestrogenic or fertile mucus is easily taught to women who are often aware of these changes but do not know their significance.

2) **The Symptothermal Method** combines all the symptoms and signs of ovulation with the temperature method.

The symptoms and signs of ovulation are :

a. **Cervical Mucus** - Secretion felt and/or seen at the vulva.

b. **Abdominal pain** - On the side in which the ovary has released the ovum. It can be sharp and radiate to the groin or thigh or is felt as a low backache. When recognised by a woman this symptom is very significant. (Its presence was confirmed repeatedly in the WHO research study.)

c. **Breast** - Discomfort, tingling or pain, or temporary enlargement, due to oestrogen stimulation.

d. **Spotting of blood,** or pink or coloured mucus in the vagina due to rupture of the ovum.

e. **Mood changes,** Varies in women. Maybe euphoria or depression.

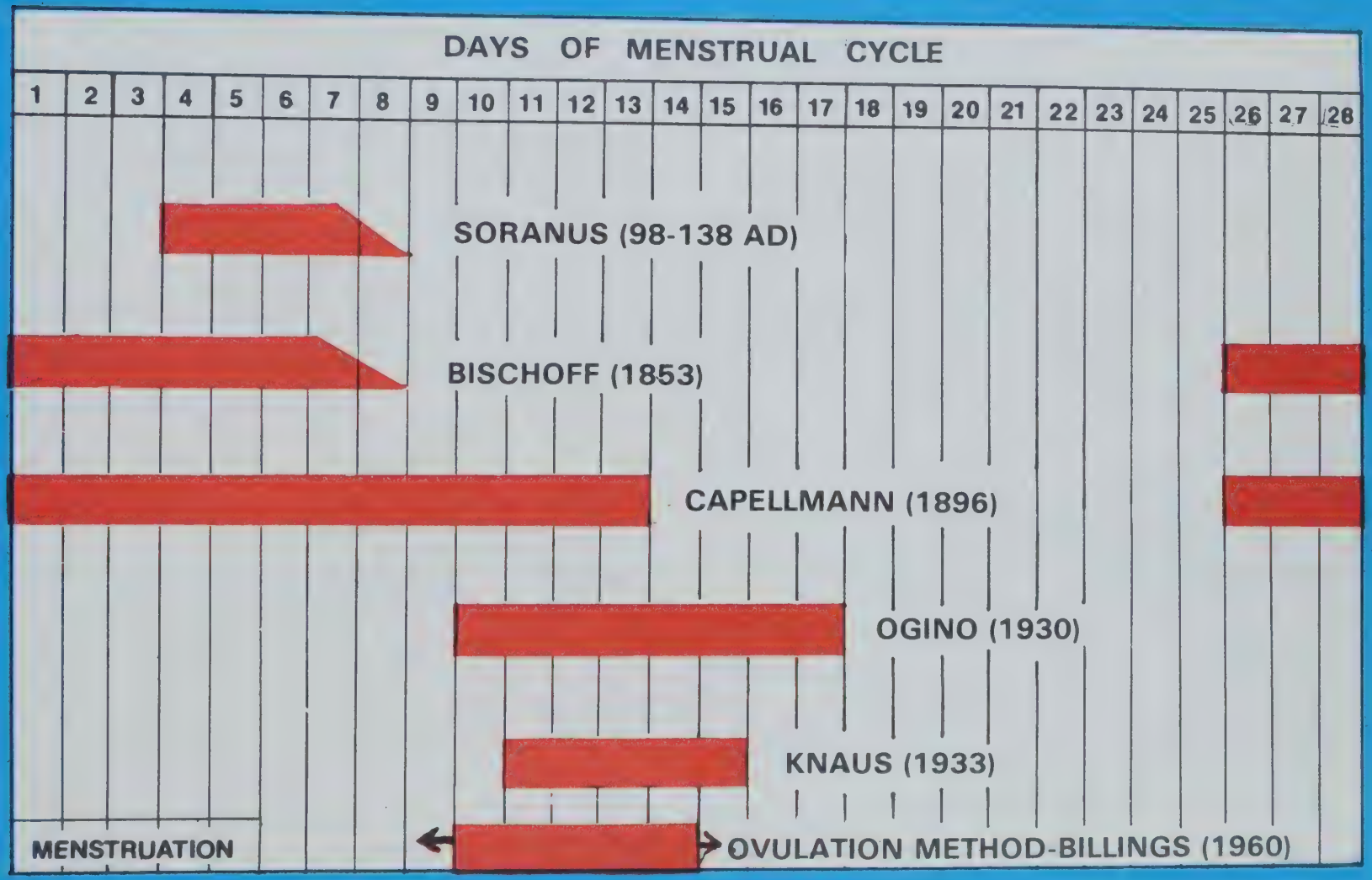
3) **The Basal Body Temperature Method.**

The temperature method is based on the scientific fact that after ovulation there is a rise of basal temperature due to progesterone. This is a post ovulatory method, and the couple is required to abstain even before ovulation. This makes the abstinence unnecessarily long.

Like all things natural, these natural methods of family planning are harmless, reliable and acceptable in any condition of health, literacy or socio-economic status.

The research for the fertile period has long preoccupied scientists. The O.M. (Billings) gives us the most modern and scientific knowledge of it.

HISTORICAL CONCEPTS OF THE FERTILE PERIOD



MALE REPRODUCTIVE SYSTEM

The Male Reproductive System consists of 2 glandular organs or testicles, which are contained in the scrotum. **The Testicles** or testes produce the male sex cells or sperms, which are microscopic in size.

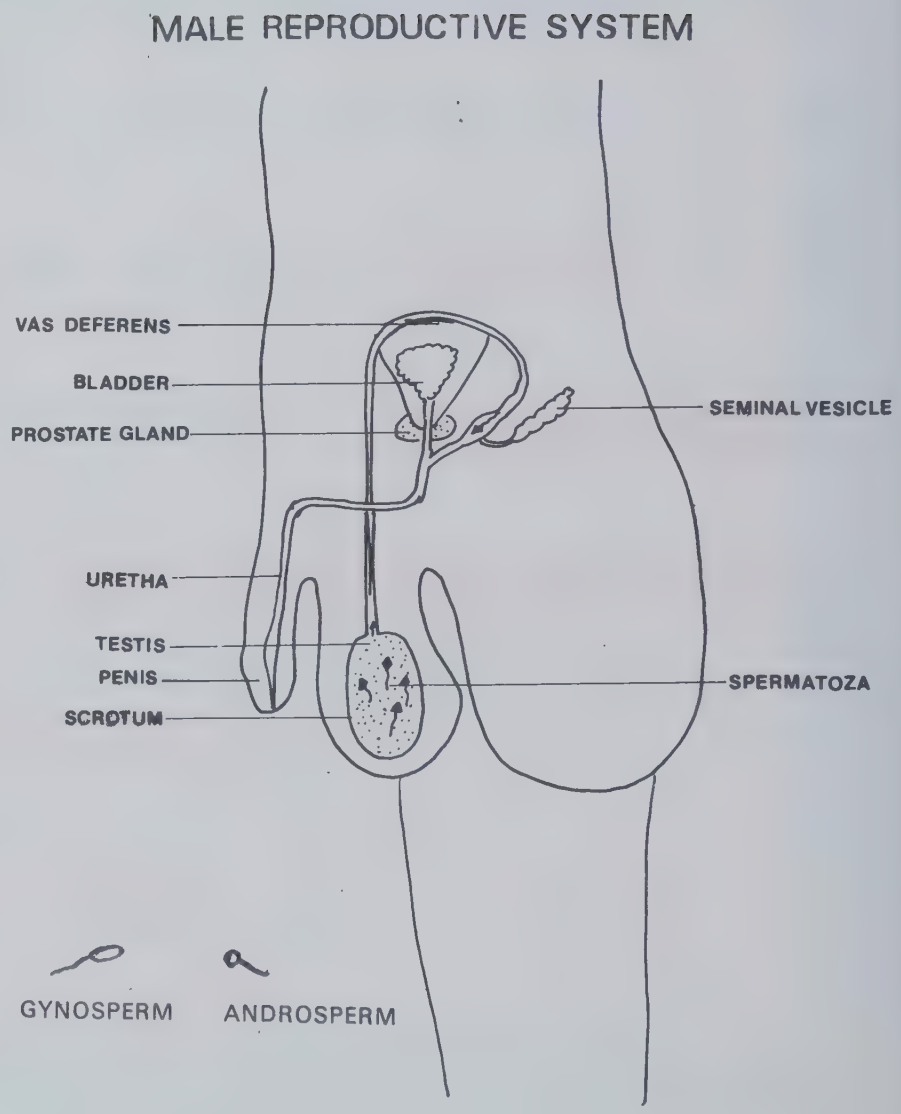
The **penis** or male organ serves to discharge the sperms. The **prostate** gland produces a secretion for the sperms. **The Seminal Vesicles** are a store house for the sperms.

The production of sperms or spermatogenesis begins at the time of puberty (around 13-14 years) and continues till the sixties or later. It is a continuous process, unlike ovulation (which occurs only once in a menstrual cycle).

The sperms are stored in the testicles and in the seminal vesicle and at the time of intercourse they are discharged in a fluid called seminal fluid or semen through the hair-like tube known as the **Vas Deferens**, and are carried to the exterior by the urethra.

The testicles also produce the male hormone, testosterone, which is secreted into the blood stream and causes the boy to develop the secondary sex characters at puberty like hair growth (beard), voice change etc. The penis lengthens, thickens and hardens when stimulated in the process of erection.

During intercourse, the male ejaculates about 400 million sperm cells into the vagina. Only the fittest sperms nourished by cervical mucus survive to pass through the cervix into the womb.



FEMALE REPRODUCTIVE SYSTEM

The female reproductive system is made up of the **Uterus** (or womb) and two **ovaries.**

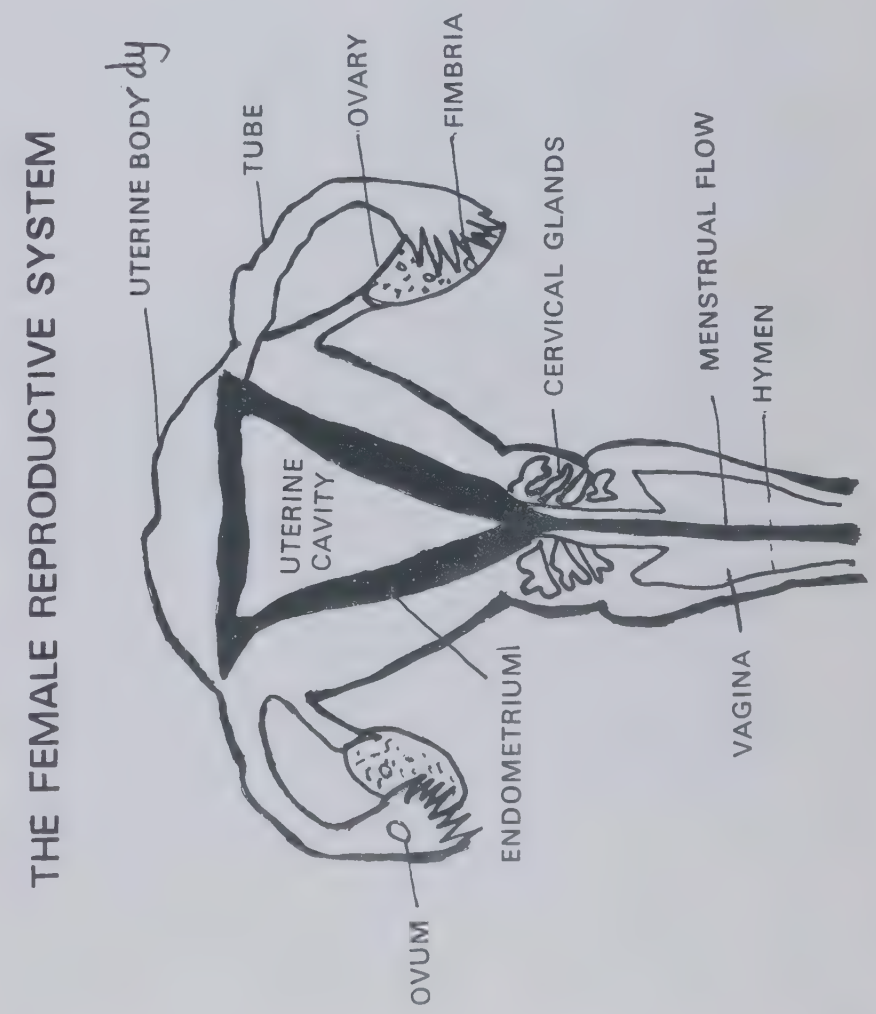
These organs lie well protected within a bony and muscular framework known as the **pelvis.** The uterus is a pear-shaped muscular organ with a lining (endometrium). It enlarges to hold the growing baby. Two narrow muscular tubes, the Fallopian tubes, are attached to the upper part of the uterus, one on either side.

The neck of the uterus is narrow and is known as the **Cervix.** It opens into a hollow muscular tube known as the **Vagina.** The vagina lies between the bladder and the rectum and its external opening is partly closed by the hymen, a membrane which remains intact unless penetrated at intercourse or broken by exercise.

The **Ovaries** are two almond-shaped glands which lie near either end of the tube. They produce a mature egg nearly every month in a process known as **"ovulation".** Usually, alternate ovaries produce one egg which bursts out of the ovary and is grasped by the fimbrial ends of the tube.

The new-born baby girl possesses about 300,000 of these egg cells but only about 400 are destined to reach maturity after puberty and only a few of these will ever be fertilized. In India the average age of menarche, or the first menstrual period, is 12 years. Soon after menarche ovulation starts occurring.

The egg cells or ovum develop within a follicle which secretes oestrogen. When this follicle has released the ovum it closes and heals rapidly and within it appears a thick yellow mass called the **corpus luteum** or yellow body which secretes **Progesterone.**



Oestrogen the feminising hormone is responsible for the symptoms and signs starting before ovulation (i.e. mucus secretion of the cervical glands and breast changes) and the development of the endometrium. Progesterone further affects the lining of the uterus, developing it and thickening it.

If the egg is not fertilized, the supply of progesterone tapers off towards the end of the menstrual cycle and the endometrium disintegrates into the menstrual discharge. If fertilisation has taken place, progesterone continues to be secreted, first by the corpus luteum and then by the placenta (afterbirth).

Progesterone has one other major function in each cycle as during pregnancy, it prevents the thalamopituitary complex, the master control centre of the reproductive endocrine system, from secreting those hormones that would cause the ovary to release an ovum. Hence during pregnancy, both menstruation and ovulation are suspended by the hormonal message from the new human life in the fertilized ovum.

HUMAN REPRODUCTION

THE MENSTRUAL CYCLE

Introduction

The menstrual cycle is the result of a complex interaction among the reproductive hormones released from the pituitary gland and the ovaries. A woman's cycle is a hormonal pendulum, its course is intricate and largely automatic, moving back and forth between ovulation and menstruation.

The four reproductive hormones are:

* Follicle stimulating hormone (FSH)
* Lutenising hormone (LH)
* Oestrogen and
* Progesterone.

The role that each of these hormones play is described in the section in Phases of the menstrual cycle.

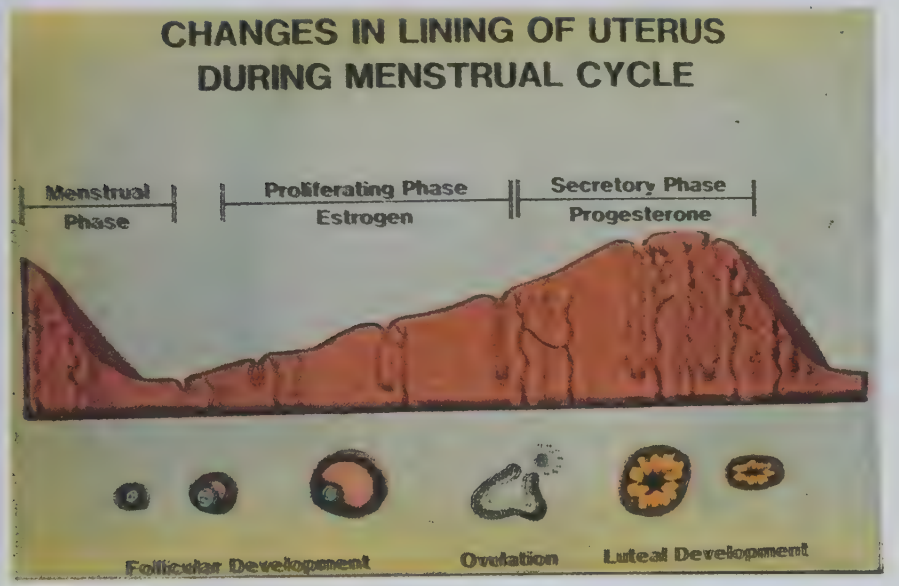
A normal menstrual cycle varies from twenty-three to thirty-five days. Irregular cycles, short cycles (those less than twenty-three), and long cycles (those longer than thirty five-days), occur from time to time in **all women.** Irregular cycles are more common at the two extremes of a woman's reproductive life-menarche and menopause. Irregular cycles are also common in other circumstances, such as after weaning a baby, and under conditions of severe stress.

The menstrual cycle consists of four phases:

* Menstruation when bleeding occurs
* The Pre-ovulatory Phase.
* Ovulation
* The Post-Ovulatory phase.

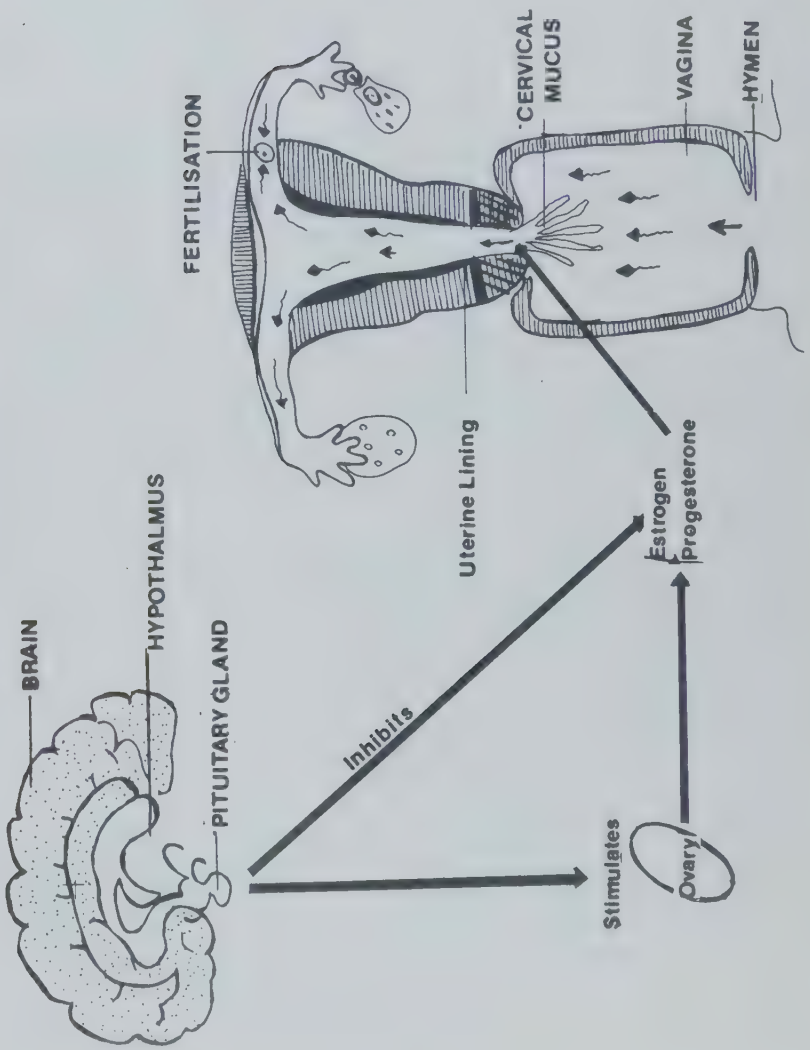
The Bleeding Phase—Menstruation

The bleeding phase of a woman's cycle is called **menstruation.** It is the external sign of what is occurring within the woman's body, namely, the sloughing off and expulsion of the inner lining of the uterus, called the **endometrium.** If a woman becomes pregnant, this part of the **endometrium,** that had been in the process of being prepared through hormonal activity for the implantation of the fertilized egg, is retained and is essential for the embedding of the baby, and hence menstruation is suspended.



The number of days of bleeding vary between one and five. Heavy bleeding of over four days may result in anaemia. The blood lost is not impure.

HORMONAL CONTROL OF FEMALE REPRODUCTIVE SYSTEM



Pre-Ovulatory Phase

The pituitary gland, under the control of a centre in the hypothalamus, is one of the great relay stations in the brain, and secretes a hormone called the **Follicle Stimulating Hormone** (FSH). FSH circulates in the blood and reaches the ovaries. This hormone is responsible for the **early growth of the follicle** which matures.

The pituitary gland then secretes another hormone called the **lutenizing hormone** (LH). This hormone is responsible for stimulating the rupture and release **of the ovum at ovulation.**

FSH and LH together produce Oestrogen in the ovaries.

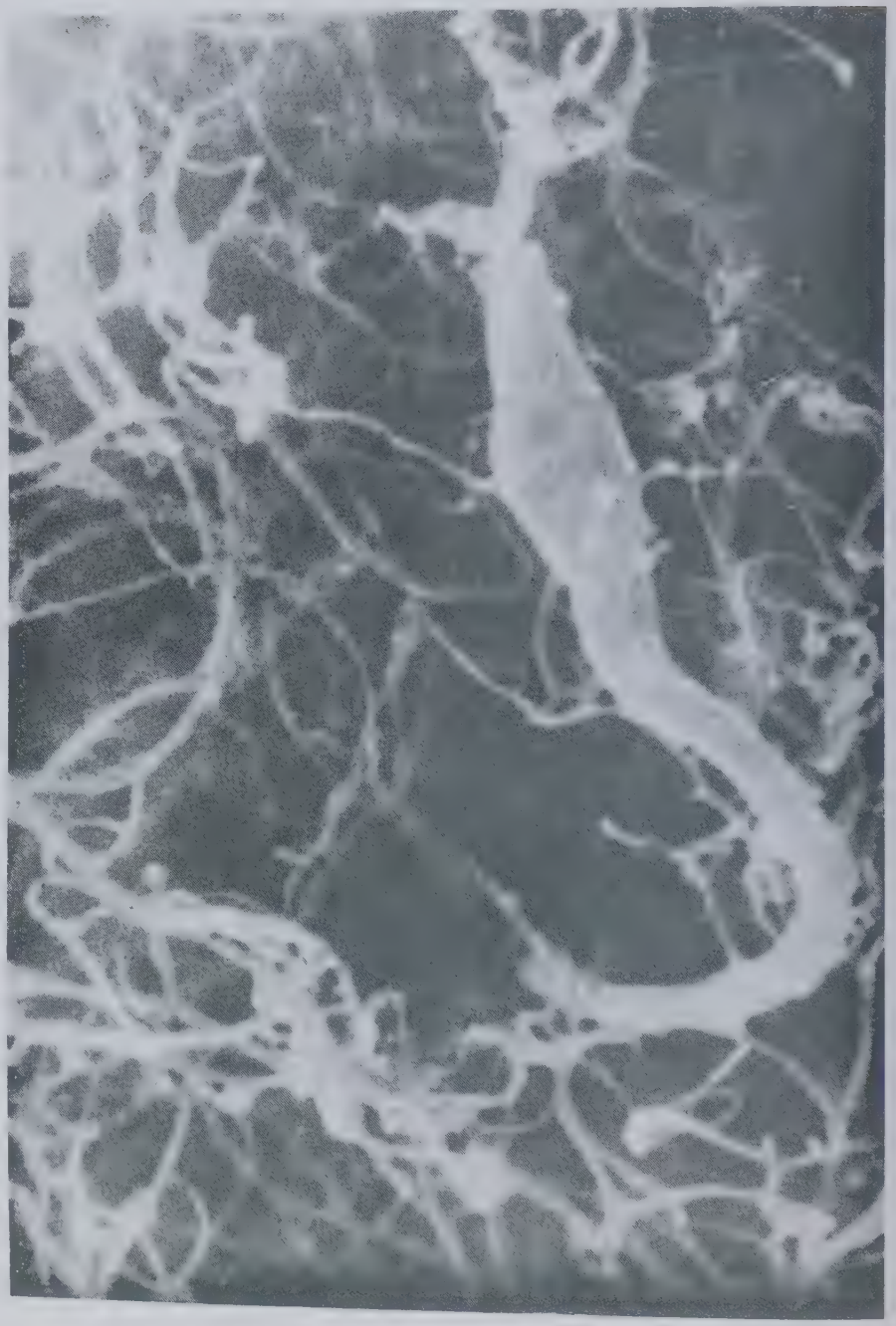
These three hormones (FSH, LH, and Oestrogen) are the important reproductive hormones responsible for what happens within a woman's body during the pre-ovulatory phase of a woman's menstrual cycle.

The pre-ovulatory phase varies, since the length of a woman's cycle is determined by the occurrence of ovulation and not by menstruation, and the secretion of the hormones vary in women.

Ovulation

Ovulation is the process of releasing the egg from the ovary. It occurs only when Oestrogen reaches a "**peak**" level which "triggers off" both the ovulation and the stimulation of the cells lining the cervix of the uterus, to produce a very special type of mucus. This mucus is called the "fertile-type mucus" and it has special characteristics. It is stretchy, clear, egg-white, producing a slippery, lubricative sensation in the women's genital area.

"The sperm swimming freely in fertile mucus"



"The sperm enmeshed and dead in infertile mucus"

The mucus can be clearly felt by a woman as it creates a sensation of wetness which was confirmed in 99% women using the method in India.

The fertile type mucus is very important because it enables the sperm to maintain its fertilizing capacity.

Transport, It also transports the sperm from the vagina through the intrauterine cavity to the fallopian tubes by providing channels and a protective environment for the sperm.

The mucus also provides **nourishment** to the sperms since it contains glucose and various chemicals for the sperm as it journeys to the tubes. The mucus also captures and destroys damaged sperms. **Unless this fertile-type mucus is produced by the cervix, conception cannot take place.**

Genesis of Human Life

If intercourse has taken place within 12–16 hours of ovulation, the ovum is directed into one of the fallopian tubes by the finger like "fimbria" which gently sweeps the surface of the ovary. The ovum may encounter the male sperm in the outer third of the uterine tube. The sperm may then fertilise the ovum which now becomes a single cell "zygote". Thus new human life begins at **Fertilisation.**

Thus twenty-three chromosomes of the sperm merge with the twenty-three chromosomes of the ovum. This new human being has within it all the inherited characteristics of his/her personality such as the color of eyes and hair, physique, and bio-chemical make-up.

If the ovum is not fertilised, it dies and degenerates. About fourteen days later (or between ten and eighteen days),

the endometrium breaks away and menstruation occurs – and the cycle begins anew.

It is the hormone, progesterone, which is responsible for supporting new life by providing nourishment to the endometrium. Within a day or so after fertilization the zygote begins the process of cellular cleavage, first into two cells, then four, then eight, etc. By the third or fourth day after ovulation the human zygote or embryo is in the uterus.

The individual cells formed by the ongoing cleavage are called "**Blastomeres**". At the end of about 4 days, the combined blastomeres form the **Morula**, which is a solid cluster of blastomeres. By the fifth day, this morula has begun to enlarge and become hollowed out, and at this point it is called a "**Blastocyst**".

From the 2nd to 5th week, with implantation, developmental changes occur in the blastocyst and this is the period of organogenesis (formation of new organs). By the 6th week a full complement of organs is present, though still in a primitive stage. By the 7th week stimulation of the mouth or nose of the embryo will cause it to flex its neck. By the 8th week at which point the conceptus is called foetus—rather than an embryo—there is a discernable electric activity in the brain and it is possible to get an E.E.G. reading. Toes and fingers are now clearly visible.

SEX DETERMINATION

There are 22 pairs of Autosomes, i.e. body chromosomes and one pair of sex chromosomes in a fertilised ovum. If each of the 2 sex chromosomes are X then the resulting individual will have XX sex chromosomes and be a girl. But if the sperm carries the Y chromosome or androsperm (X is a gynosperm) the resulting individual will have XY chromosomes and be a boy. The PH (acid or alkaline) of the cervical mucus also has an effect on the X and Y chromosome.

CHAPTER 2

The Ovulation Method

* Is based on sound scientific knowledge.
* Is natural and therefore completely harmless.
* Does not require pills or gadgets.
* Can assist many couples to achieve pregnancy if they so decide.
* Helps to establish physical and emotional harmony in marriage as both husband and wife share in Family Planning responsibilities.
* Is used very successfully by simple and literate women throughout the world—95-98 percent effective.
* Once learnt, the method can be applied to all variations throughout a woman's life i.e. in:

  * Regular Cycles
  * Irregular Cycles
  * Anovular Cycles
  * While breast feeding
  * Approaching menopause
  * Passes down from mother to daughter.

"Natural Family Planning is defined as a dialogue leading to responsible parenthood.

It is based on an awareness and acceptance of the cyclic phases of fertility."

This knowledge of the O.M. can be used by a couple to either achieve or avoid conception. No matter how irregular the cycle, the method, once learned, can be applied throughout the whole of a woman's life.

THE CYCLE AND FERTILITY

A BASIC PRINCIPLES

1. **Cycle:** A menstrual cycle begins on the first day of the period and ends when the next period begins.

2. **Husband's Fertility:** A husband, if fertile, is potentially fertile continuously, i.e. throughout each cycle of the wife.

3. **Wife's Fertility: A woman's fertility depends on ovulation (the release of the egg or ovum from the ovary) and lasts until the death of the egg.** Ovulation occurs on one particular day in each cycle, usually 10-18 days prior to the next period.

4. **Combined Fertility:** The fertility of a fertile couple depends on :

   a) The presence of a **fertile mucus secretion.**

   b) **Sperm survival** time.

   c) **Ovulation** and ovum survival time.

5. **Mucus Secretion :** This is a healthy sign of the approach of ovulation. It is produced by the special glands of the cervix prior to ovulation and is necessary for sperm survival and transport.

6. **Sperm Survival :** Prior to ovulation, in the presence of fertile mucus, sperm may survive 2-3 days. Rarely, it may be longer. Even if the sperms live longer, they lose their fertilising power and mobility. If there is no fertile mucus, the sperms die within a few hours (8-10).

7. **Beginning of the Mucus :** Some days before ovulation a woman will become aware of a sensation of wetness or notice a mucus that is non-stretchy and non-slippery, or perhaps a plug of mucus. This is the beginning of the ovulation mucus.

8. **Mucus Changes :** Over the next few days the mucus changes in appearance and texture and may show one or more of the following characteristics.

OBJECTIVE SIGNS	SUBJECTIVE SYMPTOMS
Appearance :	*Sensation :*
thin	wet
clear	slippery
stretchy	lubricative

9. **Peak Day :** The last day on which a woman observes any of the indications of fertility (appearance and/or sensation-see 10) is the day **of peak fertility.** It is not necessarily the day of maximum quantity. It is the last day of 2 or more days of the wet sensation.

10. **Ovulation and mucus changes after Peak :** Ovulation follows the peak day. The mucus changes from the fertile type to the sticky, non-stretchy type, or dries up altogether. (Occasionally, due to hormonal fluctuations, there may be a return to fertile type mucus, indicating that ovulation has not yet occurred. This may occur during times of stress).

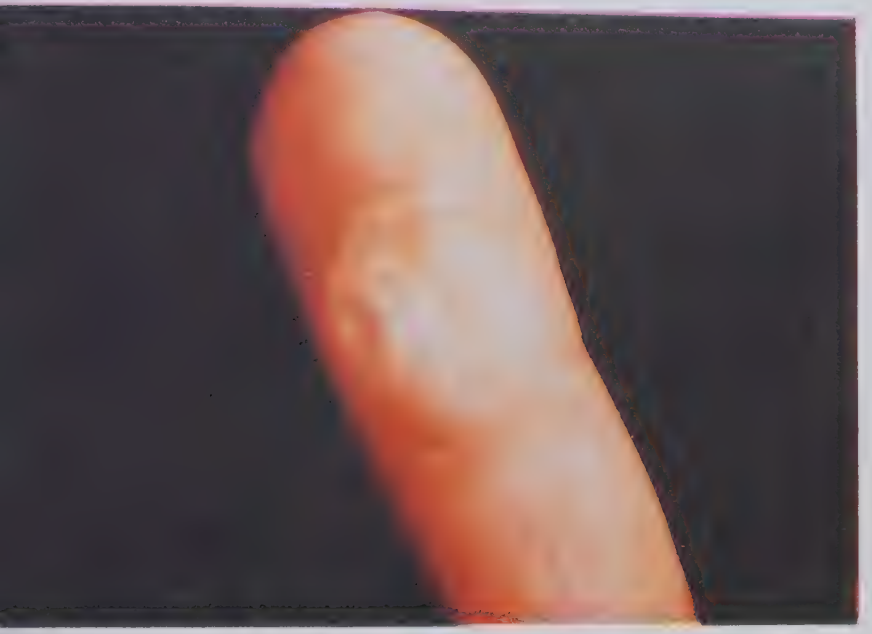
    Since ovulation follows peak up to 48 hours, and the egg survives for 12-16 hours, fertilisation is possible for three days after peak: hence the numbering of fertile days after peak is 1, 2, 3 when abstinence is required.

11. **The next period :** 10 to 18 days (average 14) after the peak day the next period usually occurs; hence the approximate arrival of the next period can be predicted.

12. **The Fertile Period :** The time in each cycle when conception may occur begins with the onset of a woman's preovulatory mucus secretion or wet sensation; it ends on the morning of the fourth (4th) day after peak.

B HOW TO START USING THE O. M.

You will find the instructions on the back of your chart, Read them carefully.



Abstain for the Preovulatory period in the first month: It is advisable to abstain from intercourse and genital contact during the first month of charting, to enable a woman to observe her normal mucus pattern. Following intercourse a woman will be aware the next day of a flow of seminal fluid from the vagina. This may resemble mucus and cause confusion in recognising the onset of preovulatory mucus. Hence this need for abstinence in the preovulatory period of the first cycle.

Record Nightly : The last sign or symptom of the day is recorded before retiring, by means of a coloured pencil. Several observations should be made during the day by:

a. awareness of sensation, dryness, wetness, slipperiness, stickiness

b. direct observation of mucus

c. any other signs of ovulation. (see page 2)

These observations must be continued carefully for every day of the cycle even after "peak" is determined, making special note of days 1, 2, 3 after peak. If there is a return of any fertile mucus during the three days after "peak" (or at any other time) this must be recorded as fertile and the appropriate rules applied.

Preferably a description of the symptom (appearance and sensation) etc., should be written in the space below the colour whenever there is mucus. Record any other signs during the mucus phase—e. g., spotting, pain, etc. and any changes in daily routine (sickness, travel, etc).

In order to detect errors in the use of the method by the couple it is helpful to mark with a dot on the chart the last act of intercourse ahead of the fertile days and the first act after they are ended, or any acts during the fertile period.

3. **Follow-up Interview :** It is important to keep in touch with your teacher while learning the O.M., or at any other time when uncertainty occurs due to any change in your ovulation pattern. In the follow-up interview you will be advised on the use of the method according to your particular situation, e. g., pre-menopause, following childbirth, planning pregnancy, etc., and the teacher can help you to learn to interpret your own mucus pattern from the information recorded on your chart.

C. RULE OF THE O. M. TO AVOID PREGNANCY

1. **Period :** In a short cycle mucus may be present during the end of the period and be masked by the blood. Therefore, it is advisable to abstain from intercourse during the menstrual period if pregnancy is to be avoided, especially while learning the method.

2. **Early infertile Period :** When a woman is experienced with charting, all dry days following the period are safe and intercourse cannot result in pregnancy.

Dry day, safe night : Intercourse in the early infertile period should be confined to night time only. The day after intercourse will not be dry because of the flow of seminal fluid. **Until experienced, record the day following intercourse with a wet symbol or mark and avoid intercourse on that day.**

"Early Safe Days Rule—Dry day, safe night, and if used avoid intercourse the next night."

3. **Fertile period :**. Abstain from intercourse and genital contact during the fertile phase that is from the beginning of the mucus symptom until after the morning of the fourth day after peak.

Note : If there is a return of any fertile mucus during this time then count again 1, 2, 3, days after peak or the last day of this fertile mucus to the morning of the fourth day, before intercourse is resumed.

4. **No contact of genital organs** : During the fertile phase, even contact of the sexual organs can result in pregnancy. Withdrawal is definitely unsafe.

5. **Late infertile period:** This begins on the morning of the fourth day after "peak" until the next period begins. During this time intercourse may be freely indulged in.

6. **Stress situations:** For e.g. travel, sickness, operations, emotional upsets, accidents, bereavements, etc.

These situations may affect mucus and ovulations patterns. Ovulation may be **prevented or delayed**. In such circumstances use "early safe day rule" and avoid all mucus days during that cycle. Ovulation never occurs early, hence you cannot be caught unawares.

7. **Missed period rule:** If an expected period does not start, follow the method as already described. If the rule has been followed there is no fear of pregnancy.

8. **Bleeding between periods or Spotting:** Ovulation may be accompanied by bleeding or spots of pink or brown mucus between periods and these days must be regarded as potentially fertile and intercourse may be resumed on 4th day following, cessation of bleeding and/or mucus.

9. **Variation of the normal cycle:** After childbirth, breast feeding, miscarriage or coming off the pill, and when approaching the menopause, hormones are disturbed and the time of ovulation may vary. Ovulation may not occur as before or normally with the first sign of fertile mucus. Therefore, during this time until normal cycles occur, the "Early safe Day", rule is used all the time. All patches of mucus of 3 days or more, or any fertile mucus or spotting, should be treated as fertile, that is abstain until the 4th day after the last day of fertile mucus or spotting.

Simple Analogies

The understanding of the O. M. can be related, to everyday life. For e.g. A seed in the soil requires moisture to grow into a plant. Similarly, a male egg or sperm needs the moisture and nourishment of the mucus to be able to join the woman's egg and become a baby. Since this moisture, like rains, comes only at a particular season or time, a woman can easily discover when she can have a baby. At this time she begins to feel wet and she can often see the mucus. If she wants to have a baby, this is the time to have a intercourse with her husband. If she does not want to have a baby she must avoid intercourse for the days she is wet and for three days after. In this way she cannot get pregnant.

In the dry infertile days, like a seed in dry, hard soil, the sperm cannot live and fertilise an ovum. (see Diagram).

Many other simple examples for rural couples, like the insemination of cows taking place only when the farmer sees the mucus at the cow's vulva, can be used.

Doctors and nurses can make good teachers only if they do not become too technical. If they can keep the method as simple as it truly is, they can do wonders.

Simple **"Barefoot Teachers"** who are using the method and teach it in their own area make the most successful teachers.

"A WOMAN AND HER FERTILE PERIOD"

"Only a fertile soil allows a seed to grow into a plant".

"Only in the fertile period can a sperm fertilise an ovum and produce a child."

A SUMMARY OF POINTS NECESSARY FOR USE OF THE O. M.

Fundamental Principles

1. Every woman who is able to bear children notices that at some time between two menstrual periods she has a vaginal discharge which is called mucus.
2. This white discharge is not an abnormality. It is an indication of good health and tells the woman that it is now the time when an act of intercourse may cause pregnancy.
3. When the mucus begins it is opaque and sticky. Next it becomes stretchy, or wet and slippery, like the white of an egg. Then it becomes sticky and thick again, and usually stops altogether.
4. The most fertile days are those when the mucus is stretchy, wet and slippery, and for a few days afterwards.
5. Sometimes a little bleeding occurs between one menstruation and the next.

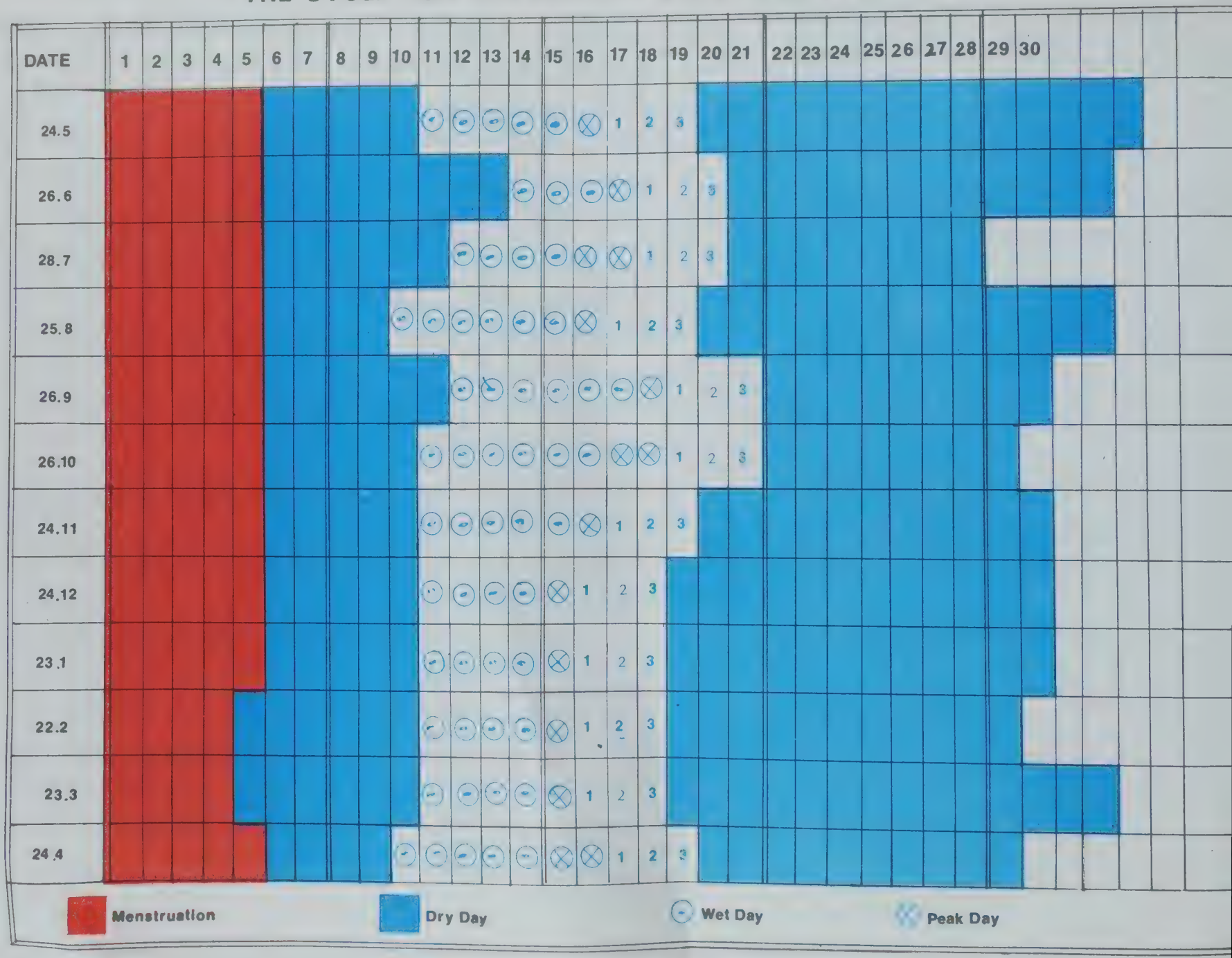
If you do not wish to have a child:

1. Avoid intercourse during menstruation until experienced in use of O.M.
2. Avoid intercourse on days when the mucus is present and for at least three nights afterwards.
3. Avoid intercourse on days of slight bleeding and for at least three days and nights.
4. The Ovulation Method can be applied successfully in all circumstances. It does not matter whether the cycles are regular or irregular.
5. In order to practise the Ovulation Method, there are three important things one must know:
   a) The time of ovulation.
   b) That the egg that comes from the woman's ovary lives in the tube for only up to twelve or sixteen hours.
   c) The sperm from the man can live inside the woman's body for two-three days. In rare cases with healthy mucus it has lived for five days but has already **lost** its power of fertilising.
6. If there is any doubt of the type of mucus it is better to observe abstinence once any mucus appears to see what follows.

   If the mucus is thick and sticky and is followed by dry days, then it would be safe to resume marital relations, preferably on the second night of consecutive dryness.

   The sensation which results from the presence or absence of the mucus are observed in the course of normal activities and do not require internal examination for recognition.
7. No two cycles will be exactly the same and very great variation may occur unexpectedly. The cycles may vary in length. The number of dry days will vary and the number of mucus days will vary. There is no need to worry.
8. The user must learn to rely on her ability to trust in her genital sensation which is more reliable than the observance of mucus.
9. The husband must have access to the chart and be involved in the decision and use of the O.M. for effective use.
10. After a few cycles the woman who has been well taught and trained herself according to instructions, will make most of these observations automatically. Even so, she must be advised never to become complacent because her pattern of fertility can change with age or special situations and will only be known to her through her daily observations.

"THE OVULATION METHOD—AN ACTUAL CHART OF Ms A."



CHAPTER 3

Profile of a Successful NFP Teacher

The successful teacher is one who:

A. Is completely convinced that NFP methods are
—Safe.
—Effective.
—Acceptable.

B. Has kept a chart (and if unable to chart because of menopause or having undergone a hysterectomy, has learned the method correctly) and has followed at least 5 different couples successfully for a minimum of 6 months each.

C. Has been **under supervision** while doing B, and should have access to another expert teacher for consultation in difficult cases or for referral when there is a genuine controversy.

D. Has the **skills** needed to transfer her knowledge to the couple or woman in such a way that the O. M. is understood.

E. Has the ability to **counsel** and thereby **help** a couple to make a decision to accept the method.

F. Is **empathetic. Sympathy** is to **feel for, empathy** is to **feel with.** The teacher becomes a partner to the couple, growing with them, and adapting her knowledge to their status and situation.

G. Is a NFP **problem solver** and not a medical, psychological, nutritional, or other problem solver. (Always keep into perspective your own expertise and your own limitations).

H. Is **patient.** Not all problems have to be solved at once. The teacher must stay behind the couple. A temptation to get ahead or in front of the couple, must be overcome.

I. Adopts an attitude that there is no problem that cannot be solved. If the teacher does not know the solution she can discuss it with a colleague or say "I don't know, but I'll try to find out".

J. Finds that if she cannot follow up a couple, or if she cannot establish rapport with them, she should refer them to another teacher.

K. Having had a couple who "fails" the method, goes on to learn from the failure, and improves her technique and

approach to problems. If she has "failed" the couple in any way she should admit her mistake.

L. Is a continual NFP user. Even if unmarried, she should chart. Since NFP involves sharing the experience of what happens on a monthly basis within a woman's body, this information is best imparted by someone who herself has learned to recognize and interpret her physiological signs of fertility and she should be skilled to advise in special situations like pre-menopause, coming off the pill etc.

M. Is a **motivator :** The NFP **teacher** needs to be able to motivate couples to adopt family planning (that is, either for the need for spacing and the health of child, or mother, etc.) and motivate the mother/couple to use NFP as a method of fertility regulation.

N. Is an **instructor :** An NFP teacher must have a firm knowledge of the female and male reproductive systems, role of cervical mucus, and other methods of family planning (artificial methods).

O. Possesses methodological expertise. She must know how to teach and also be able to adapt the style and content of her teaching to specific audiences (literate/illiterate etc).

P. Scores at least 75% on the NFP Teacher Test and feel, confident of her ability to handle different couples and keep uptodate with new knowledge etc.

Q. Is an **effective Communicator.** An NFP teacher needs to know how to identify couples who may want to use NFP (the target audience) and the best means to reach different couples (door-to-door, publicity, etc). Being able t identify the key people in a region or village (such as th traditional dai) and involving them is important.

R. **Possesses personal qualities** such as a non-judg mental attitude and is able to accept couples where the are and lead them from there. Warmth, acceptance, and supportive attitude are key components of the personali of the NFP teacher.

S. Is an **evaluator**: The NFP educator needs to possess skil in evaluating the effectiveness of the teaching. This is a on-going process that may require additional training. Bu it is essential that an awareness exist of the importance evaluation.

PART – I

SYLLABUS FOR TEACHER TRAINING

FIRST TOPIC—MARRIAGE

Marriage, its aims and objects.

How a good marriage is built up ?

— How the partners contribute towards it—Love, Sex ar Marriage.

— Aims of marriage

1) To foster a mutual relationship of love.

2) The bringing up of children with love and concern.

— **Object - Sociologically, to build up a stable fami that contributes towards building a healthy ar stable society.**

— Humanly speaking, to love, help and comfort each other.

— A good marriage is built up by fostering love between husband and wife which will result in mutual agreement in regard to style of life, occupation, career and size of the family.

— By accepting one another which include their needs, temperamental make up, their aspirations, anxieties and interests.

— Society plays an important role in building up a good marriage.

It must accept and recognise marriage and make available all facilities a society has within itself, which will build up a happy, loving community.

— The couple should be able to distinguish between love and sex.

— Love is an expression of total giving of oneself to another.

— Sex designates all that makes man and woman different; not only the sex organs, but all sexual characteristics such as the external appearance of body, the voice etc. Sexuality includes also the emotional and psychological differences.

— A family is a confluence of a threefold love

1. Conjugal love (between husband and wife)
2. Parental love (towards children)
3. Filial love (towards parents)

— *See chapter on the Couple and NFP*

Second Topic—FAMILY

"All humanity passes by way of the family".

(John Paul II)

What are Family Values?

The Society is a system wherein there is constant interplay among resources and institutions which govern the individuals, groups and communities with the basic social unit. The family is one such institution, which is the basic unit for satisfaction of the needs of the individuals that comprise it. Such needs vary from biological to psychological and economical. This primary organisation, the family, is the basic point of distinction between human and animal society.

Historically, the family has undergone several changes emerging from a **"hard and fast social structure or institution and becoming a flexible human relationship."** There is a great dependence between family and society.

In turn, the family contributes to the society by acting as a socialising agent and as the means of control.

Hence, while acting as an agent of social control, the institution of the family too undergoes changes within it, being influenced by the production of the larger social unit.

Thus the family, is a micro reflection of the changes taking place in the macro society. Family has not only the element of social control, but also the potentiality to be an agent of social change. In brief, not only it is affected by the larger social unit, but can affect also the social unit. *(James)*

To Summarize the Positive Family Values

— Family is the smallest unit of society. Husband and wife must recognise fully their own duties towards God and

towards society in a correct hierarchy of values.

— Husband and wife are bound to keep up their marital relationship in harmony and thereby fulfil each other.

— Duty towards family consists in bringing up children, feeding, educating and giving them positive values.

Third Topic — THE DUTIES OF PARENTS TOWARDS EACH OTHER

— to communicate with one another

— to foster love, humour and respect towards each other

— to be loyal to one another

— to care well for the family and home.

Duties of parents towards children

— to live at home and care for children. They should not be separated. While the father is at work, the mother should feel it a privilege to care for the family. The man should not leave his wife and family for long periods of time.

— to train up the children at home.

The home is the greatest training school in the world. It should be ruled according to the plan that God has for the family—**the first school of Love.**

The Duty of Family to the Country

Each family is the smallest unit of a country, hence the family has a responsibility to build up the country. A family can improve the country by providing her with good citizens.

Fourth Topic — POPULATION PROBLEMS IN INDIA

The population of India is today over 700 millions. It is estimated that 14 out of every 100 persons in the world are Indians and they are increasing at the rate of 2% annually –i. e. by about 13 million a year.

Effects of Overpopulation

— Poverty and unhappiness in the family and society

— Sickness— high maternal mortality and morbidity
— premature and infant death

— Malnutrition — due to inadequacy of food — especially in young children

— Illiteracy — progress in education has not kept pace with population growth.

— Unemployment — Asia, with about 55% of the world's population has a poor share in the distribution of wealth. The per capita income in many developed countries is over Rs. 2000/— p. m. (India approx. Rs. 150/- p. m.)

Keeping in mind these ill effects there is only one solution if we want to improve our family, society and nation, and that is to educate the family. **In the final analysis population is a social and familial problem because it is related to the most intimate of acts and the institution of marriage and family life. Consequently Family Planning is part of the framework of family life.**

WHAT IS FAMILY PLANNING ?

Family planning is the planning that parents should do with regard to the number and spacing of their children, taking into account the needs of their children,

as regards loving care, food, health, education, employment and their duties to society. When a couple cannot have a child (sterile) adoption should be encouraged after all efforts fail. Helping infertile couples is also a part of Family planning.

Parents should be thus educated to "responsible parenthood".

PART – II

SYLLABUS

The Model for a NFP Teachers *

The teaching for new NFP users requires the **transfer of knowledge** from the teacher to the client. How well this is accomplished depends to a great extent on the skills of the NFP Teacher. This transference involves skills which first need to be **identified** and later need to be **developed** and **refined** in a teaching model.

Teaching Model

The model is **dynamic** because the process is active and filled with motion. There is an ongoing communicating ebb and flow between the teacher, the client and back again. The process is **interpersonal** because it is a process which occurs between human persons and with all of the implications of that type of interaction.

There are 7 basic concepts which, interacting in this fluid-motion, make up this model.

1. **Identification**—This is a process of actually recognizing that certain situations or problems exist in the use of NFP for the particular couple. (Eg. "My husband travels a lot and that makes it difficult").

2. **Interpretation**—This is the process of explaining the nature or meaning of that which has been identified.

3. **Integration**—This is the process of bringing together all of the situations or problems that have been identified and/or interpreted, so that a complete or whole concept of the client's needs is developed.

4. **Clarification**—This is a process of elucidation; to make clear and understandable what is the real value at stake.

5. **Dialogue**—This is a conversation in which two or more persons take part allowing for the free flow of information to occur from one to the other and back again.

6. **Recommendation**—This is the process of giving advice.

7. **Assimilation**—This is the process of absorbing the information or internalizing it so that information becomes useful and meaningful to the user.

**Adapted from "Fertility Appreciation". The O.M. of NFP by Hilgers T.W.M.D. USA.*

TABLE 1

STAGES IN NFP TEACHING

IDENTIFICATION → INTERPRETATION

CLARIFICATION
↓
DIALOGUE
TEACHER—CLIENT
↓
INTEGRATION
(Teacher Assimilation)
↓
RECOMMENDATIONS
↓
CLARIFICATION
DIALOGUE
TEACHER—CLIENT
↓
INTEGRATION
(Client Assimilation)
↓
Satisfied and Successful Users
↓
Recruiting other users
↓
Becoming Teachers

A Teacher must acquire a quiet dynamism which brings out her skills and abilities for the couple's successful and enthusiastic use of the method.

IDENTIFICATION—Dialogue between teacher and client.

In general, the process begins with **identification**, develops into an **interpretation** and, with either single or multiple situations/problems which end with the teacher integrating the various pieces of information. This integrative process allows for a wholistic picture or concept for the situations/problems to be developed. The teacher then has the capability of assimilating all the data in preparation for making appropriate recommendations.

The hub of the identification, interpretation and integration triangle is the process of clarification. A teacher should be able to convey her belief in the method to the couple in this dialogue. See Table 1. This is the dynamic process which involves **dialogue** between the teacher and the client couple. Specifically, it dictates against the unilateral flow of information from only the teacher to the couple. In this process, the client couple becomes an integral participant in the educational and learning process. The flow of information becomes bilateral. **The dialogue is one between persons and not toward persons.**

RECOMMENDATION AND ASSIMILATION

Once the teacher has assimilated the basic situations/problems which a couple possesses, then the teacher can properly make recommendations to them so that learning can occur. It is important to state that this is an individualized process. Once the recommendations have been made to the client/couple there is a second generation clarification process which must occur. Again, dialogue between the teacher and the couple in a free flowing manner is the instrument through which this clarification process occurs. It is essential that such clarification should occur so that the clients can now integrate the various recommendations and make them a constructive element in their new learning.

As the recommendations become integrated, the clients move toward the assimilation of the new learning. **The ultimate requirement for the successful use of natural family planning lies in the ability of the client couple to enter into this assimilative process.** Indeed, **If a couple does not internalize** the information necessary to use NFP, it will not be a satisfactory learning process. Successful internalization means a successful and satisfied user couple.

TABLE 2

POSITIVE MOTIVATION DESIRABLE

Negative and Positive Situations Affecting Couple's Choice

Negative Situation	**Positive Motivation**
Children : Too many Too soon	Use of a family-planning method
Too costly	Use of an NFP method
Fear of complication : Pill Devices Surgery	Use of a method which enhances the marriage, the health and dignity of wifehood and motherhood.
Distrust of methods (barriers, for instance)	
Fear of spiritual loss and sanctions.	

"Teaching NFP to a Couple, and to young Mothers"

PART III

SYLLABUS

COUPLES NEED 3 C's. - Teacher and Couple

1. COMMUNICATION 2. COOPERATION 3. CONCERN

When 1 or more of the above are not present in the marriage you can imagine the problems there will be in the marriage. In such a marriage if one or other partner uses contraceptives there may be a resentment felt by that partner and communication between husband and wife may decrease even more.

TABLE 3

Behavioural Influence in NFP

NEED		DESIRED BEHAVIOUR— LONG TERM MOTIVATION		
Spacing children or limiting family size	→	Charting of fertility indicators	→	Self Knowledge
Natural fertility control	→	Identification of fertile days	→	FERTILITY AWARENESS
Growth in love		Abstinence on fertile days	→	SELF MASTERY
		Selective intercourse on infertile days	→	CONJUGAL MASTERY
	→	Development of other loving behaviour	→	Improved personal relationships
				A family with healthy stability.

(Table 2 and 3 from Review of NFP, Vol V, Nos 2/3, 82 Mary Catherine Martin).

TABLE 4

NFP TEACHER'S MOTIVATIONAL GUIDE FOR FOLLOW U

An Investment in your healthy and happy future by th

Long Term use of Natural Family Planning A Day In an

Day Out, Year In and Year Out Method

A TEACHERS GUIDE FOR FOLLOW UP

1. BASIC PRINCIPLES

After initial follow up (within a month)
Follow-up every 6 to 12 months
Observations are reviewed
Instructions are reviewed
Motivation and encouragement is provided
Scheduling follow-up is couples responsibility/
Teachers supportive encouragement needed.

2. REASONS TO CON TACT NFP TEACHERS OF CENTER

Appointments for follow-up
Charts and coloured pencils
Method related questions
Suspicion of pregnancy by couple
Appointment for pregnancy confirmation
Any change in Intention of use
Needs for referral by couple
Review situating in a counselling manner.

3. MOTIVATION FOR CONTINUED CHARTING

Important for successful use of Method
Provides an excellent health record
Contributes to confidence for both spouses
Aids in decision making
Assists couple participation
Is considered necessary for high effectiveness.

4. MOTIVATION FOR COMING TO FOLLOW-UP

Periodic evaluation of past use
Source of motivation and encouragement
Excellent means of updating record/use,
Changes in reproductive category (eg. pre-menopause after child-birth etc.)
are discussed.

CHAPTER 4

The NFP Centre

ORGANIZATION AND ADMINISTRATION

Natural Family Planning (NFP) is an educational process whereby a couple is made aware of their combined fertility. This "awareness" leads to a dialogue which when stabilised helps to strengthen the other aspects of marital life, i.e.: the psychological, social and familial, (i. e. with children).

The practice of NFP is comparatively easy, therefore, when an **"openness"** or when **"communications"** already exist between the couple. When it does not, the awareness is not so easily followed by sharing of fertility knowledge.

Much of the success, therefore, of the successful practice of NFP depends upon the **"manner in which"** NFP is introduced into the life of the couple, **"the time"** at which it is introduced and by **"whom"** assumes an importance which most NFP programmes have not given due consideration.

SCOPE OF ACTIVITIES OF A NFP CENTRE

1. Family Life and population Education for parents, teachers and students.
2. Counselling for Sex education.
3. Marriage Preparation Courses.
4. Responsible Parenthood.
5. Maternal and Child Welfare and Creche Services.
6. Family Counselling.
7. Study cells statistics Research.

SELF ENERGIZED FAMILY

NFP fits very well into the recognized need for an **"energized family"** in which as a self-help group, the family itself, and in this case the couple in particular becomes competent in the case for their own health and happiness.

This concept has shown itself welcome in many spheres of health activity. It is manifested in the woman's health movement which is teaching self-reliance; it is manifested in programmes to enable people to care for themselves better without having to go to a doctor.

Moreover, it fits in very well with our ideas on health education about helping people achieve **"their goals"**, *not ours. It fits in well with our ideas of voluntarism and an activated society.*

HOW ?

It is getting quite clear that for NFP to succeed and spread, its purpose and manner of presentation is important.

THE AIM IN NFP IS NOT MERELY TO ACHIEVE THE LIMITATION OF THE FAMILY BUT TO STRENGTHEN FAMILY VALUES AS A WHOLE. Therefore, we cannot afford to ignore the **"matrix"** or **"framework"** which incorporates or projects NFP.

Ideally in planning programmes together with the short term benefits it is the long term benefits that assume major importance and the **"how"** of NFP teaching can be summed up in having a good programme of **"Family Life Education"**, which starts before marriage.

When NFP, which is based on periodic abstinence, inculcates values of mutual understanding and trust and is projected as a means to attaining **"fulfilment"**, it **"appeals"**, has a wider **"acceptance"**, and is **"adopted"**.

WHEN ?

The **"when"** is not disputed. It is best accepted in premarital and early marital years. In high schools and colleges, in Family Life Education programmes, the philosophy of NFP must be introduced, for it is at this time that the youth intellectually experiment with the idea of self-discipline, and crystalize their values.

BY WHOM ?

The subject of **"by whom"**, should a couple be educated into the practice of NFP, has great significance. At a recent meeting of international experts it was stressed that a NFP teacher be most carefully chosen for—

1. The image she projects herself of NFP—not as a religious ideal, but as a **"wholesome sexual practice"** is very important.

2. The success of world-wide programmes where lay and married people either singly or in couples are the teachers cannot be overlooked, and therefore, certain conclusions need to be drawn from this fact and stressed upon especially where new programmes are being organized. Since NFP covers the area of "sex", the role of the married laity is an "in-depth" one and their scope of activity is indeed **"wide"**

3. The need of **"team work"** in which every NFP programme has available, trained lay teachers is a must. Religious must delegate the main bulk of teaching to them, and occupy themselves more with "organization and coordination" which is itself a major task. Religious in health work can make good teachers.

   There is a need for every NFP teacher to be a **"counsellor"** and as such the qualities of a counsellor need to be incorporated into that of the teacher. (See chapter "The NFP Teacher".)

4. The **"involvement of all cadres"** of people in the community need special attention. It is here that religious leaders, health personnel, educationists, and social workers, must pool their talents and form an **"integrated NFP service"**. They need a programme of education themselves to be suitably equipped.

5. Once the NFP programme is organized a built in system of evaluation and continued expansion needs attention. This aspect of "follow-up" has not been sufficiently recognized in India.

ORGANIZATION, FOLLOW-UP AND EVALUATION

"At the root of every success there is some form of well-directed energy. Success is like a flower, it may appear more or less suddenly, but it is the finished product of a long series of efforts, of preparatory stages."

REMEMBER :

"IF YOU ARE NOT CERTAIN OF WHERE YOU ARE GOING. . . YOU MAY VERY WELL END UP SOMEWHERE ELSE!"

ORGANIZATION :

1. DEFINE YOUR OBJECTIVE
2. PLAN OUT YOUR PROGRAMME
3. CONTINUALLY EVALUATE YOUR PROGRESS.

Starting NFP work in your city Hospital Village

Go step by step and ask yourself these questions :

1. Which couples need NFP immediately?
2. Who could profit from NFP at a later date?
3. Who could add his/her voice to support your programme?
   a) Have you enlisted their support ?
   b) Do you have enough scientific data to convince those who are well-meaning and helpful but sceptical ?
   c) Have you formed a group of suitable Co-workers ?
4. Have you got literature regarding NFP in the 3 major Languages spoken in your area ?
5. Are you and your teachers sometimes/often available at fixed places at fixed times ? and is this known to those who fall into answers to 1, 2 and 3.

If all your answers are in the affirmative then go AHEAD

The following organisations exist in many towns and cities and can help in one way or the other.

1. Hospital, Health or Social Service and Community Centres.
2. Pastoral Council of the parish which has separate Committees e.g.
3. Family, Education, Socio-economic.
4. Gandhian Association/Naturopathy Centres.
5. Teachers' Guides, Women's Social Service Organisations.
6. Parish Associations/Organisations.
7. Family Welfare Life Centres.
8. Marriage preparation programmes.
9. Youth organizations.
10. Educational Institutions.

Now you can have your first meeting with those who are interested, or who can help. Get everyone to participate and give their views. Form a NFP Committee and plan your strategy.

EVALUATION BY THE CENTRE DIRECTOR AND TEACHERS

1. Talk to your teachers

2. Talk with your teachers
3. Have them talk together
4. Show teachers how to teach.
5. Supervise them
6. Give them practice by providing opportunities for practical experience.

To do the above the NFP Teacher must:

1. Be a good listener

Check—Can you listen without interrupting ?

Do you listen but without mentally giving your whole attention ?

2. Be friendly

You can only be friendly if you respect your couple client. Do you respect them as you do yourself ?

3. Treat any information as confidential

Or do you make use of any information you get in the course of your work to show how much you know ? or do you respcet intimate facts told to you ?

4. Be sincere and trustworthy

Do you make promises which you do not keep ? Do you misinform people who know less than you because they do not know better ?

5. Like the people she works with

You may have to search for points of identity, but honestl try to like the people you work with.

6. Be able to delegate Responsibility

Give other teachers opportunities to discover their ow potential. Give increasing responsibilities to others i test situations.

NATURAL FAMILY PLANNING ORGANIZATION

Recruit teachers from Satisfied clientele
↓
Clients
↓
Training programmes
(Group & Individual)

Consolidate extende services
↓
Clients
↓
Doctors,
Clinics/Hospitals/
Community Centres

I Stage

NUCLEUS
NFP Teacher at Centre

Press Publicity
Distribution of
Leaflets/Booklets/
Literature/Films/
Slides/Charts.

II Stage

Talk to groups—
Associations
Informal Talks
Talks in Parishes—
Patients

NFP CENTRE TASKS—SPOT CHECK

SUMMARY

I. Publicity — The aim is to create awareness. It should provide information and motivation to the general public. House to house contact — user to friend contact, etc.

Teaching aids — Printed material available in English and in the Vernacular, Journals, Pamphlets, Leaflets, Charts

- — Slides, Films, Posters
- — Fertility awareness programmes
- — person to person contact
- — Family Life Education courses
- — Women's Health groups
- — Marriage Preparation courses

Illiterate - Radio - TV - Films - Slide shows - Charts

II. Teacher Update

Refresher course: Once a month for three months. Then monthly for teachers. All cases should be documented for further use and teaching. Director to meet teacher locally and invite support of others. Individual teacher problems discussed as they vary in each local environment.

Bulletin to Teachers: Latest findings, useful experiences, case studies, etc.

Teacher: check knowledge, disposition, conviction, whether she charts herself, possesses all teaching material, regards NFP seriously, resolves to learn more, to follow up users successfully ! Perseverance and enthusiasm. A quiet dynamism needed. New teacher recruitment from users. Barefoot teachers.

III. Record Keeping

Charting initially necessary — must check charts of users monthly — Teacher must keep duplicate chart for discussion and data purposes.

—Rural areas — chart —smaller size, alternate ways of charting explored.

—Cooperation in filling charts by husbands encouraged.

—Teacher to correctly interpret charts

—Red/Blue pencil for charting —for visual satisfaction and easy identification

—Records and statistics sheets to be maintained.

—Time of charting —frequency of intercourse (IC)

—Stress rules of method :

Dry days-infertile
Wet days-fertile
4th day after peak-safe to resume sexual relations

—Charts should be kept for at least 12 months and thereafter if change of status such as pregnancy, lactation, premenopause, illness.

IV. Follow-Up : is very necessary. It provides an opportunity for health education in hygiene, health care, marriage counselling, etc.

Discuss —user couple satisfaction

—psychosexual problems, other problems, alcoholism, etc.

—ambivalence for another child, inlaw problems

First three months— every fortnight if feasible
Next 12 months—once in a month
Thereafter, once in a way, for statistics or and problems. Discuss problem.

V. Evaluation and Study

1. Positive value of Ovulation Method and its use.
   Health of wife—(breast feeding)—family health and stability
2. For use effectiveness : Cost involved returns
   Value of integrated programmes.

TERMINOLOGY

1. CONTACT — A woman or couple who has attended a talk shown keen interest in Natural Family Planning.

2. ACCEPTOR — REGISTERED

An acceptor is a woman whose husband has agreed to follow NFP and together with the wife agrees to follow the method for spacing or limitation. The acceptor should be in communication with the teacher to discuss any problems she may have with the method.

3. USER

A user is a woman who has been successfully followi NFP for at least 3 months as ascertained by the Teacher examination of her chart and her seriousness about usi NFP as judged by the teacher. A User is a Registered case.

4. AUTONOMOUS COUPLE

A user and her husband who have been successfully pra tising the method for a period of nine months to a year und supervision of a teacher and is confident, is an Autonomo Couple.

5. TEACHER

A teacher is one who has been trained at a recogniz centre and certified to be a teacher in NFP by following couples for at least 6 months. A teacher should at first have limited number of couples under her supervision.

6. A CO-ORDINATOR

A co-ordinator is an experienced teacher who is in char of two or more teachers and who regularly supervises a co-ordinates the work of a region or sub-centres.

7. A CENTRAL CO-ORDINATOR

A central co-ordinator is one who regularly meets, ordinates, solves problems, discusses cases, compiles da and generally supervises the work of all the co-ordinators an area.

8. COOPERATOR

A cooperator is one who has been trained in and appreciates the use of NFP. May be a man (doctor, lay). He/she refers couples to the NFP teacher in the area and helps in follow up and motivation.

9. METHOD FAILURE

In this case the couple have faithfully and correctly carried out the instructions yet a pregnancy has occurred. All methods of preventing pregnancy have such failures.

10. USER FAILURE

In this case the couple has made a mistake due to a fault in understanding, which may itself be the result of inadequate teaching, or the husband and wife have carried out the instructions as they understood them, but did not understand or interpret them correctly, or the couple has broken the rule of abstinence in the fertile period.

11. THE TOTAL PREGNANCY RATE

This is really a measure of the motivation of a group of people to continue to use a particular method. The total pregnancy rate largely reflects the non-use of the method and has reference to acceptability, continuation rate, etc.

In the use of Natural Family Planning methods there will always be a significant figure for the total pregnancy rate. The husband and wife are allowed to retain their fertility, and with full knowledge of what they are doing, some will make a free decision to depart from the use of the method.

NFP is a Part of Health Education

> "Health Education is the application of behavioural science to health problems, with a view of modifying behaviour for the achievement of physical, mental and social well-being."
>
> *– B. K. Tones*

The NFP Teacher as a Health Educator: Stage of learning

There are 3 stages in any attempt to modify human behaviour :

1. A Cognitive stage
2. An Affective stage, and an
3. Action stage

1. Cognitive Stage : This is the first stage in the educational process To overcome it you need to be good at "Communications"–and give adequate information with appropriate explanation. Above all the learner must be motivated to go through this stage. This is a critical stage and deep understanding is needed if the teacher has to clear up misunderstandings and doubts regarding NFP.

2. Affective Stage : When the teacher is affected by this knowledge an attitude is developed which is a predisposition to action. Once a favourable attitude is developed, it is only a matter of time that the third stage is reached.

3. Stage of Action : To facilitate this stage, the learner must have access to the use of NFP and the teacher now uses all these educational tools to give the finer points of the techniques of practice.

Caution : People will confuse NFP with Rhythm. Be very firm and point out the scientific basis of NFP as compared to Calendar Rhythm.

"Coming Together is the Beginning;
Keeping Together is Progress;
Thinking Together is Unity;
Working Together is Success".

DIARY OF A NFP TEACHER

FIRST VISIT : Went to see Mrs. Shanta in her home as I was told she had a baby and thought she might need Family Planning. Found her nursing her 3 week old baby. Sat and talked to her. Her breast milk is plentiful and baby is gaining weight. Told her she should discuss NFP with her husband and I'd come again. Left some NFP literature with her.

SECOND VISIT : Two weeks later met Mrs. Shanta on my way to see another case, she told me her husband was interested in F.P. but that neither of them knew much about it. We agreed on a day and time for her to see me at the Centre.

THIRD VISIT : Two days later Mrs. Shanta came and I explained with the help of my charts about a woman's fertility, conception, etc. Gave her all the details of Ovulation Mucus Method. She was enthusiastic about it, but not sure of her husband's reaction. She said her breast milk was decreasing and I advised her on diet and fluids to increase the flow. I warned her that ovulation could take place and gave her a chart and coloured pencil and asked her to mark the squares starting immediately. I gave her an information leaflet for her husband to read and told her when she could meet me, after a week and with her chart. I asked her to abstain from intercourse and to explain to her husband that she might ovulate soon, hence the need for caution, and careful observance symptoms.

FOURTH VISIT : Mrs. Shanta did not come as agreed upo so I went over one evening. Met her husband who told m she had flu ! I saw her and ensured myself that she was ta ing the right treatment and rest. Then I asked her husban separately whether he had read the NFP leaflet. He had an said he had many questions to ask. I had brought my Demo stration File and so explained to him how the use of NFP base on scientific factors could mark out the fertile periods in woman's menstrual cycle. He had been unaware of this an I was able to explain many misconceptions and superstition When breast milk decreases, progesterone activity decrease and oestrogen activity is increased and ovulation may occu Therefore, I told the husband the need for being alert to mucu secretion which precedes ovulation. He felt very happy an uplifted to know how with the simple use of biological fac he could by co-operating with his wife avoid a second preg nancy till the first baby was 3 years old. I asked them bot to keep in touch with me, and to fill their chart every nigh starting from today.

FIFTH VISIT : Examined Mrs. Shanta's chart three week later she had marked PEAK twice in the first cycle, as she wa unsure of fertile mucus. Saw her chart fortnightly. Th second marking was correct and two months later she wa found to be happy and confident. Her husband had told h that though he found abstinence a problem in the beginnin he realised that it had helped her to respond much better whe they had intercourse, and so for the first time both now foun their sex life satisfactory.

Aim for practical action – in all your talk and work. Don force the pace – but take a step forward with every encounte

CHAPTER 5

"The Couple and NFP" Positive aspects of Periodic Abstinence for the Educated Couple

Sexuality is not Genitality

Sexuality is masculinity or feminity in its truest and fullest sense. It is not genitality. It is not just for reproducing; it includes a bonding that goes beyond the mere experience of physical sensations in intercourse – the sensations without the bonding are but a counterfeit of true sexuality. For sexual attraction first of all draws us out from within ourselves and impels us to interact with others (it is said to engender feelings of compassion and tenderness for others).

But the bonding requires a fundamental regard for one's husband/wife as a whole person, with a mind, a soul, a heart, and a precious body. Regarding others as whole persons rather than as one dimensional object enables the basic energies of sexual attraction to remain free for genuine love.

Many simple and ordinary couples liken periodic abstinence to the cultivation of courtship before marriage in each cycle. Others say that during pregnancy, when there is no family planning reason to abstain, the special benefits of periodic abstinence are missed. And when some couples are faced with abstinence during pregnancy, because of threatened miscarriage, their mutual continence, sometimes prolonged, is a great gift, disposing them as parents to receive with profoundest love each other and the child whom their selflessness will allow to see the light of day at birth.

It's true that **abstinence dynamics** sometimes illustrate the "forbidden" or "inaccessible" fruit syndrome: once denied, the attractiveness of a thing grows. Of course some couples complain about the abstinence time when they "can't have intercourse" but also don't seem to make use of the days when they "can". The situation calls for some very honest evaluation.

The time of abstinence is a time that couples can use to make a point **to do things for each other,** to expand the basis of their relationship instead of drawing apart, and to look ahead so that a more relaxed atmosphere can be present when the infertile time comes. The educated couple can read a current book out loud together and discuss it, or either may enter the heart of another by studying subjects the other likes to talk about. It amounts to taking time to take an intelligent interest

in the large dimensions of each others live's and those of one's friends. **The couple might make a special effort to turn outward together beyond themselves. This need not happen only at the fertile time, but the time of abstinence provides an occasion for growth not always tapped.** (Hunegar R. J. Int. Review of NFP Vol. 6, 82).

For illiterate couples, this sharing of agricultural and household talks is equally important. The dignity of the woman is also enhanced.

The Husband and NFP

At present it is generally accepted that the initiation and frequency of the sexual act is a function of the male. It may be argued that the dependence of the female on the providence of the male results ultimately in the male dominance of sexual life, and that as women develop their independence and become less culture-bound, they too will play a role equal to the male as initiators of coitus. **"NFP is one of the few ways in which a balance of this partnership can be achieved."**

While the premises on which NFP is based are **"woman-centred,"** the practice of NFP, depends more on the male than it does on the female. However well she can demonstrate her temperature or mucus changes, unless her partner co-operates by observing abstinence during the fertile days, NFP will fail. **A NFP programme that ignores the husband, therefore, has only half a basis for success.** The programmes, the instruction and most of all, the motivational approach, must also be directed to the male.

It is important to motivate the man and to remove from h mind certain biases which he may have about the restrictio that need to be imposed on his sexual life so that he can more properly disposed to the periods of abstinence.

1. **NFP is the Method where Mutuality or Partne ship is required :** The **first** thing that the man shou understand is that more than any other method of conceptio control, NFP places responsibility on the couple. The succe of the method will depend very largely on how adequate rules are kept and how well abstinence can be observed duri certain periods of time. **No other method requires so muc participation.** This is in fact the weakness as well as t strength of NFP. It is a weakness because so much is left the couple. At the same time, THIS IS THE STRENGTH OF NF BECAUSE; it reposes responsibility on the couple themselv to a degree no other method does.

Other things being equal, it does strengthen the charact of the individual, who practises it because the decision a its observance emanates from him and must be practis constantly.

2. Man's advances in technology and science in fact, Hemingway in his book "The Modern World and Self Control points out, have been possibly made by the fact that man h been able to discipline himself and control his own actio **This, not merely in the field of sex, but in all things.**

The Sexual Urge : Modern man in fact, constan exercises self-restraint. If he feels hungry, he does not mer reach out for the first bit of food he sees along the way;

purchases food or enters a restaurant to order something. If he wants to get across the street he does not merely dart out without looking first to see if traffic may involve him in an accident. If he feels a full bladder, he does not void at once, but will first seek the appropriate moment and place to do so. **Self-restraint is, in fact, the mark of the civilised man.**

3. **Thirdly**, the male realizes that he has practised self-restraint and self-control of sex in the past when as an adolescent his libido was at its highest level. This is a most important point for him to acknowledge to himself. Psychologically, he may not be disposed to the abstinence required for NFP, because he revolts at the idea of having his sexual life regulated by his wife's bodily changes, especially since he himself experiences no changes.

In marriage too there are reasons that have led to the suppression or postponement of intercourse. Peharps the circumstances were not opportune, the libido came at the wrong moment, there was an appointment to keep, the partner was ill with fever. In most cases, he had found no difficulty whatsoever in dismissing his libidinal urges or postponing them temporarily, and he thought nothing more of it. However the difficulty is, he has not done it for the purpose of avoiding a pregnancy before. And this is where the motivation comes in.

The realization that sexual abstinence is for **a purpose** will not only help to reconcile him to the abstinence of NFP, but will make the practice of abstinence all the easier. The attitude can be reversed from the original. It has not been done, so it cannot be done, to a new one: 'IT HAS BEEN DONE BEFORE REPEATEDLY, SO IT CAN BE DONE AGAIN, WHEN NECESSARY for both of us and the family's good.

4. **Fourthly** for all couples, and for all men, there are particular circumstances which enhance the libido. Most men will not find difficulty in identifying the different things that increase the sexual urge as well as identifying those that tend to decrease the urge. For some it may be a gesture which leads to the development of the sexual urge, for others the clean smell of a recent bath etc. Whatever they are, once having developed the motivation to give it a try, the enhancing circumstances should be avoided.

5. **Complimentarity of husband and wife.** How can love be expressed during the periods of abstinence? Sexual intercourse is not only the possible manifestation of love or even of sexuality. It is the most intimate means of expressing sexuality, but there are other ways of doing this too. Many sexual activities and expressions of affection remain open, without need of intercourse, and this of course, will depend very much on the couple.

The sexual relationship, like the rest of our being, should grow, develop, deepen, and mature, through the years. Is it not possible that contraception arrests this development because of its unnatural approach to intercourse? Rather than accepting intercourse as a unity, an upbuilding act which binds together, we seek to isolate the thrilling, soaring experience and enjoy only that.

"Could we ever say, for example, to a plant, give me only the beautiful red flower, never mind about the roots, the foliage, the fruit? The plant without the roots and the foliage will not flower. Would a society at peace and content with its sexuality, be so preoccupied with sex? Perhaps our sex-obsessed society is the result of so little real sexual fulfilment.

Are we seeking sex more often and enjoying it because of the widespread use of contraceptives ?'' asks Mary Shivanandan.

Conjugal Sex must be associated with love and fidelity if it is to be meaningful or lasting.

But Pharmaceuticals play fairy godmother by providing Contraceptives to allow sex without Life/Love. This separation weakens the marital bond.

If the marriage breaksdown then family life will break-down.

PSYCHO–SEXUAL BEHAVIOUR DATA

Psycho-sexual Behavioural Pattern of the Acceptors

Women's Libido : That women also have sexual urges and recognize their libido as clearly shown in recent research studies.

I. a) LIBIDO Analysis of 2,334 cycles of 250 couples regarding Libido (or the urge to have sexual intercourse), gave the following results.

Experience of Libido in Menstrual Cycle (in 1425 Cycles)

LIBIDO.	Pre-Menstr.	Post Menstr.	Menstr.	Ovulation	Not Felt
No.	556	270	13	444	142
Percentage	23.8	11.6	0.6	19.0	6.1

It can be seen that the premenstrual group is the bigge one. Together with the post menstrual group it can be see that **women experience Libido most in the inferti periods.**

N. B.

If the teacher felt that a particular couple was not likely t understand or welcome such a question she used her discretio and did not ask it. Hence we feel the answers we receive were reliable especially as they were asked to the same coupl in different cycles at different times over a period of a year. changing pattern in several instances showed that husband started to accept abstinence, as sexual satisfaction improve with adjustment to the infertile period.

The following statistics obtained as a result of ver conducted surveys carefully in England and in Italy shoul corroborate the truth of this beyond doubt : *(Fernando S. N New Leader, June 1975)*

Women who experience libido	In England	In Italy
Around the menstrual period	59%	46.8%
At any time of the cycle	39%	34.4%
At the time of ovulation	6%	11.8%

(7% in Italy could not be classified)

India (WHO & Karnataka Studies 1980)

b) HUSBAND'S COOPERATION

	Cooperative	Not Cooperative
No. of Couples—250	2106	228
No. of Cycles—2234	90.2%	9.8%

c) OBSERVATION OF RULES

	Observed	Not observed
No. of couples—250 No. of cycles—2334	2082 69.2%	252 10.2%

N.F.P. & Periodic Abstinence (DR. SR. BERNARD'S STUDY INDIA '84)

TABLE—1

Do you find abstinence difficult in following the OM.	Number	Percentage
Yes No	9 41	18 82
	50	100

TABLE—2

Growth in Relationship

Were you able to talk/ share on your relationship	a) In early Marriage		b) Since learning the O. M.	
	No.	%	No.	%
Strongly agree	5	10	25	50
Agree	8	16	24	48
Undecided	21	42	1	2
Disagree	16	32	—	—
Strongly disagree	—	—	—	—
Total	50	100	50	100

TABLE—3

The O.M. Chart and Relationship :

In what way has the chart helped you in your relationship ?	No.	%
More loving	4	8
More understanding	27	54
More Considerate towards	16	32
each other Hostile	2	4
Disharmony	1	2
Total	50	100

e) **Coital Frequency**—as actually marked on a chart is 1.9 both by median and mode assessment, i.e., twice a week. This would probably be amongst the first available Indian data obtained over a length of time and systematically.

This shows that there can be no doubt that for the vast majority of ordinary fertile couples periodic abstinence is accepted as a family Planning Method.

f) Last but not least is the fact that **approximately 50% of the acceptor couples learnt about the method from a successful user friend.** Nothing succeeds like success! This is very significant as compared to and pointed out to us by a sociologist of a Family Planning Organization which does not include NFP and who said users of other contraceptives "do not even speak of the method even in the family circle, leave alone motivate others to accept it. In India such woman to woman motivation will be very useful."

Choice, Change & Coherence—The Wife and NFP

A wife who uses NFP makes a deliberate choice to respect her body. She changes in her attitude to herself—This makes her husband change in his attitude to her. He respects her needs and her body.

The natural methods involve no risk to a woman's health. They enhance her understanding and appreciation of her bodily functions and allow her to live in harmony with her womanhood. They support the concept of a woman's body being 'fearfully' and wonderfully made, an instrument created by God, complex yet capable of being understood. They treat fertility as a precious gift of God, to be loved, respected, understood and wisely used. They leave the sexual embrace in its natural beauty. They also have a high rate of effectiveness when they are used correctly.

The feature of abstinence causes some couples to doubt the practicality of natural methods. They say things like—

We would lose the spontaneity in our love life. How can that be natural?

We would live in constant fear of pregnancy.

How can it be good to abstain from intercourse on certain days of every cycle?

My husband would never stand for that, I am afraid, he would be tempted to unfaithfulness if I denied him.

However satisfied husbands say things like—

"Life is sweet living with a natural method. It's like th honeymoon when we come back together. Our sex life ha blossomed in a new and even more satisfying way". It works This makes for a **Coherent** pattern of wifely demand for respect consideration and equality as a person in her own right However, when a wife uses contraceptives she negates herse and her demands for equality or respect are not rational c coherent. Accordingly her husband's attitude to her his als negative.

6. NFP Strengthens the Marital Communication

In the fullest development of the Human Personality ther is a need to love and to be loved and the deepest joy to b found in loving, is the joy of generosity, the exercise of one' capacity to make a gift, the denial of one's self in a sacrific of service to the beloved.

There are times in every marriage when abstinence fron sexual intercourse is a necessity and it is then that abstinenc becomes the testimony of love. To believe that both husban and wife are capable of developing this attitude is a challeng to the NFP Teacher and the couple themselves.

Femininity: The woman's chief feminine traits ar **Affiliation,** which lead her to seek a relationship and intimacy perhaps more commonly labelled as close communicatio when married with her husband, not necessarily through physical way.

The need for her to be "Empathetic" another significan aspect of femininity also makes it easy for her to becom

"out going" in the infertile period. It is here that she needs her husband to meet her in her out reaching to share.

And this is how the marriage, her femininity and his masculinity will be enriched, for it is only the strong man who can afford to be truly tender and thus make the bond of marriage a relationship of the deepest communication and most satisfying intimacy.

Germaine Greer's new book "Sex and Destiny's" main point is that Western Society has grown fatally indifferent to the values of fertility, family, and motherhood. (Greer is a famous feminist).

Greer's research in Italy, India and other Third World countries led her to conclude that the role of mother carries status and children are at the center of family life in these countries. But Westerners, Greer argues, "do not like children". Western Society will go to any length not to have children.

She finds Western Society's nonchalance about birth control repugnant. She characterizes the IUD as transforming the uterus into a "poisonous abattoir", and the woman choosing it as "an unwitting accomplice in what she may well consider to be a crime"—abortion. Taking a drug as powerful as the pill is "like using a steamroller to crush a frog", says Greer.

Uncritical dependence on mechanical and chemical methods of birth control is evidence of "our deep unwillingness to put fertility within the individual's control", according to Greer. She questions the abandonment of time-honoured natural methods of birth control. For a woman to abstain is not a sacrifice of her sexuality says Greer, but a realization that sex includes the potential for procreation.

Greer considers the intrusion of Western "family planners" into other countries as "evil". "Why should the West presume the rest of the world wants more sex and fewer children"?, asks Greer.

(Ref: Prolife News, Vol. 9, No. 2, May '84 Canada)

THE COUPLE AND NFP

Larry & Nordis Christenson,—a young American couple write about their experiences of Contraception and NFP.*

"We believe that the years have confirmed and rewarded us in our decision to stop using a contraceptive device. Our sexual relationship has developed in a new way. We love and delight in each other more. **Sexuality has become a more enjoyable natural part of our life.** We attribute this to our discovery of natural family planning. I would not go back to using a contraceptive device even if the alternative were having twenty-one children".

This experience has led us to wonder what the consequences of using contraception might be on other marriages. We know contraception prevents pregnancy rather effectively. It is much easier to see that than to ascertain what else it might do.

Could contraception be a contributing factor to the immature, unsatisfying sex life which marriage counsellors

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* *"The Christian Couple"* (Kingsway Publ.)

hear about and divorce statistics confirm? Is contraception an unsuspected blight on modern marriage?

Larry and I feel that couples should be warned against the unthinking acceptance of contraceptives. **Every married couple should come to their decision based on the best physiological, and sexual knowledge.** We believe that Natural Family Planning offers distinct advantages over the use of mechanical or chemical contraceptives. It is a viable option which merits serious consideration.

I wonder what we are really saying to ourselves when we prepare for this most intimate act by donning contraceptive machinery or by negating the act chemically?

Can we treat ourselves like machines, closing off an undesirable valve and expecting the rest of the machine to operate smoothly?

As persons we are subtly interrelated and interdependent. We are much more than a biological machine.

Our actions speak more forcefully to our deep mind than do our intellectual rationalisations. Do we set up a conflict within ourselves when we attempt to say with one action, 'I want to be with you', while with another, I reject the possible consequences of this oneness?

What is marriage? We need to come back to basics. The nature of marriage includes sexual intercourse. The nature of sexual intercourse includes the possibility of pregnancy.

Although the contraceptive mentality tends to play th down, no contraceptive method is an absolute guarantee th sexual intercourse will not result in pregnancy. The contra ceptive mentality leads us to believe that .ntercourse witho pregnancy is our right, a right all but guaranteed by mode science. There is a 'failure rate' to which every type c contraceptive admits.

Technology can Fail

The contraceptive mentality says that we have the right t sexual intercourse and also the right to reject the fruit of thi relationship and act. When we accept contraception we ope the door to more and more drastic steps to prevent or annihilat pregnancy. The right to reject the consequences of intercours is not given us by nature.

The contraceptive mentality begins by saying, 'We canno (will not, must not, should not) have a baby'. If, contrary t our expectation, conception occurs, then abortion could be th next logical step. We have a right to expect that the con traceptive will work, and if it does not, it is not our fault is it

Who can measure the unhappiness brought on by such manipulation and rationalisation? We are deceiving ourselves if we think that we can accept the privilege of sexual inter course but turn our backs on responsibility towards the frui of our action.

Society Problems solved by Contraception?

Much of the rationalisation for both contraception and abortion says that they are required because of the tremendous

problems faced by families and by society. But if to solve problems we have to deny the integrity and responsibility of our actions, we only precipitate other problems—perhaps not immediately apparent but even deeper. John Kippley says it well; **"Man should respond to the challenges of life in ways that are not destructive of authentic human values."**

Are there attitudes which carry over from non-acceptance of pregnancy to the children one already has or to children in general? Does the contraceptive mentality develop those instincts of motherhood and fatherhood needed for happy families? Our material accomplishments and acquisitions, often claim a higher priority than the emotional needs of our children. What will these priorities yield us in later life-reward-regret?

Elizabeth Kubler-Ross who has done much research on death and dying, was asked if her work with dying people had changed her, answered — 'If I were to lose this house and everything in it, I could not care less. 'If you listen to dying patients say, If only I had got to know my children. If only . . . if only, . . ." you begin to reflect on your own life. We need to reflect on the priorities we establish in our marriages.

SEXUALITY AND SEXUAL MASTERY

Man is not an animal : he can control his instincts and feelings. Man may alter the nature of his sexuality, while animals, or at least inferior animals cannot. Male butterflies strive to mate with a wad of cotton emitting the female's odor but will have nothing to do with her once she has been sterilized. An insect's brain is only a hypothalamus, a center where perceptions of attraction and repulsion converge to produce automatic relaxes of approach or flight. In man this center is controlled by the prefrontal area of the brain, where emotions or feelings are felt and which can receive the impulses of the hypothalamus without heeling them.

Because of this marvellous human nervous system, one may refuse to do something that is attractive. **"That is why Prof. Paul Chauchard has stated that man's principal sexual organ is the brain".** Any behaviour that is purely instinctive may be termed "animal". Sexual mastery renders sexuality more human, because it enables man to act according to his reason in choosing whether or not to obey his instincts. Therefore sexuality to be meaningful and responsible should be mastered. (C. Rendu Int. Review NFP No '82).

SELF-GIFT

The marital act properly performed is filled with psychological meaning, for it enhances man's personality by giving him—a) a sense of personal worth, b) a sense of achievement, c) and it leads him to perform the noblest deed viz., **self-gift out of love.**

Virgil defined his friends in these words "dimidium animae meas", which broadly translated mean "my better half". Love is a self-gift in a fusion of lives. What husband and wife cannot attain in their love, is attained by a part of themselves, father cell and mother cell which reach the peak of love when in a mutual self-surrender they fuse together into a new life. Thus husband and wife are co-makers or co-creators with God. Just as God created the world out of love, thus husband and wife out of love co-create a new human being.

Fertility Awareness

Fertility awareness was spontaneously mentioned by 58% of the couples in a study by Borkman and Shivanandan. (Int NFP Review Vol 8, 1984). Jonas' definition of fertility awareness was "the awareness of cycle phase and any moods associated with it." We distinguished three different patterns of fertility awareness from the data: (1) Knowledge of the woman's body and cycle, (2) both husband and wife feeling in tune with the cycle and being aware of hormone-related moods, and (3) respect beyond NFP for the personhood of the other, especially the woman.

Two examples of the first pattern (knowledge of the woman's body) follow. First, a teacher-user said, "When a woman becomes in touch with her body and what is happening, she says, 'I didn't know about this. This is absolutely fantastic!' A second woman said, 'After learning NFP, I got to understand my body well'."

In the second pattern, the couple become aware of hormone-related moods and feel "in tune". For example, one husband said, "I think I feel a little more in tune with my wife and in tune with the world. We are not fighting each other in terms of her cycle". A second example is a wife who said, "It is nice to be able to attribute certain things to the way my body is functioning as opposed to immaturity and moods".

In the third pattern (respect for the personhood of the other, especially to the woman), a husband volunteered, "My responsibility to my wife is to see she becomes everything she is capable off and reaching her potential as a woman and as a person".

One couple said, "NFP brought our marriage closer. W learned to communicate. We don't have to use sex for ever thing".

The following are examples of satisfaction with sex an intimacy:

"Sex is so fantastic . . . just being together in silence . . it's not how many times but what you bring to intercourse.

And another couple says:

"Sex has been getting much better. We are most pas sionate the first day of the infertile period. We both wan each other more . . . the experience of not having intercours when we could conceive is incredible for both of us."

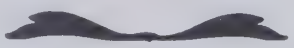
"How a Reluctant Husband became an ardent NFP User

A Muslim Couple was referred to us for Family Planning The wife had used both the I.U.D. (Loop) first and then th Pill. She was forced to abandon both because of bleedin and high blood pressure respectively. They had 5 children an could not have more. They did not want sterilisation. As th husband said "We have no choice but to use NFP, as th other methods available are ineffective". And since anoth user couple referred them to us they wanted to try th alternative.

In the monthly questioning for husband's reaction, th record for 3 months showed that he did not like the abstinenc at all, but since his wife liked the method, he was following th required abstinence.

After the third month a change in his attitude was recorded and it continued. So I decided to ask him tactfully why he had changed to a positive, helpful and decidedly cooperative attitude. He answered "I had never been used to regulating my urges, but once I started to do so, I found that in the periods of infertility when we had sex, my wife was very responsive. She was no longer a statue in the bed. So I don't mind the abstinence at all for when we have sex it is so much more satisfying now.

So we can coax reluctant husbands to try this method for 3-4 months before deciding it's not for them!



CHAPTER 6

The Teenager and Fertility Awareness

TALKING TO TEENAGERS

Each girl has her own 'biological clock', centred in the brain, that sets her menstrual cycles in motion. Generally between the ages of eleven and fourteen, the pituitary gland just below the brain, influenced by the 'clock', signals the ovaries to begin producing the hormone, **oestradiol**, in sufficient amounts to cause breast enlargement, maturing of the sex organs, and emotional changes. Changes in the uterus also occur which make menstruation possible.

The beginning of the menstrual periods is called the **menarche** and usually occurs at about thirteen years of age, although it may occur as early as ten or as late as seventeen.

The first year or two is a time of menstrual irregularity for most girls, but then the cycle settles down to a pattern (usually of twenty-three to thirty-five days) from the beginning of bleeding to the last day before the next period begins. This phase of fluctuating hormones plays an important role in growth processes and future reproduction.

Natural irregularities of cycle length should on no account be manipulated by the Pill and other hormones to bring about regularity. Women can be quite HEALTHY a have IRREGULAR cycles all their reproductive lives. TREATMENT IS NECESSARY.

Most girls do not ovulate for the first year or so af menstruation begins, that is, their ovaries do not release an e ready for fertilisation and a possible pregnancy. The hormon are priming the reproductive system, getting it ready for la fertility.

In the beginning the signs of fertility may not be prese But, by knowing about the mucus changes that sig the body's emerging fertility, you can recognise it when arrives. At first there will be some infertile, sticky or th mucus coming from the vagina. Gradually over several mont the cyclical fertile pattern of slippery, stretchy mucus resem ling raw egg white will be seen. This is fertile mucus a signals impending ovulation.

After ovulation the second hormone from the ovary, p gesterone, plays its part, producing a cessation of the fert mucus pattern. Sometimes infertile mucus is observed.

At times, when ovulation begins, periods may beco rather uncomfortable, even sometimes severely pain

Hormone treatment to stop ovulation may stop the discomfort, **but such treatment is also known to have dangerous effects reaching into the future,** one of the worst being damage to fertility so that your capacity to have a child may be affected.

Other treatments are available for pain which are not harmful. **Hence it is advisable to avoid hormones.**

It is important to have a clear understanding of the signs of fertility. This knowledge is healthy and useful throughout life. It is also a good feeling to understand the changes of your body. Moreover it is a matter of convenience to be able to anticipate the menstrual period. It is also important to know that the fertile mucus is not a disease requiring treatment. It is a normal, healthy sign.

The mucus plays a vital role in fertility, because it is essential for maintaining the vitality of the sperm cells. Because the fertile mucus is so favourable to sperm cells, they can travel through it to reach the egg, and fertilise it, even if close sexual contact without actual intercourse has occurred.

It is good to keep a chart while you are learning about your fertility and to see for yourself the changes in mucus as well as the sensations it produces.

Cervical Cancer

The female reproductive system matures slowly over several years. A young woman should weigh up the health risks of early sexual activity. **It is now known that the risk of cervical cancer is highest among women who start sexual relationships at an early age, and who have more than one sexual partner.**

Gonorrhoea

Future fertility can be jeopardised by contracting **Sexually Transmitted Disease** (S.T.D. or V.D.) especially Gonorrhoea, if it is not diagnosed early. By the time symptoms develop, or even severe illness, the fine lining of the Fallopian tubes may already be damaged preventing the transport of sperm and egg, or causing the fertilised egg to lodge in the tube instead of the uterus. Damage to tubes from S.T.D. cannot be undone.

"If you want to grow, Learn to Say No."

If you are involved in a sexual relationship, the greatest dilemma you face could arise from pregnancy. Every act of intercourse in the fertile phase carries with it the possibility of a pregnancy. So the possibility of conceiving a baby needs to be carefully considered if the prospect of intercourse arises. **Remember "No" is a Love word.** A weak or a wrong "Yes" can harm your womanhood. So take care.

Some of the information given to adolescents concentrates on methods of contraception, without mentioning that the best and most foolproof method of avoiding pregnancy is abstinence.

If a pregnancy does occur and an abortion is contemplated, it is worth considering that damage to the cervix in order to abort, may cause it to become incapable of carrying a later pregnancy to term. Even after the immediate hazards of an abortion are overcome, support and guidance are often needed

to recover from this experience as the psychological side effects can be very serious.

It is worth thinking about possible consequences of these problems now.

"ADOLESCENCE is only the beginning of Biological Readiness"

Dr. Kingsley Davis says in a paper presented to the U.S. Commission on "Population Growth and the American Future."

"The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread."

An Interesting Study of American Teenager NFP by Dr. Hanna Klaus M.D.

Massive provision of contraceptives to teens have failed to halt either the incidence of teen sexual activity, pregnancy or S.T.D. In view of the known psychodynamics of adolescence, sex, pregnancy and maturation, we chose to offer fertility awareness/natural family planning via the Billings Ovulation Method after explaining the program to the parents, and requiring the volunteer subjects to obtain parental consent to enter the program, while assuring client-teac confidentiality. The rationale for this approach was

1. Adolescence marks the beginning of biologi readiness for parenthood. The integration of this fact i ego and gender identity are major maturational tasks of adol cence. The psychodynamic of contraception perforce assig a value of 'nonimportance' to the teen's procreative capaci

Since the teen is trying to integrate this central value i his/her personality it is absurd to expect consistent use something which goes counter to the maturational thrust.

2. To achieve comfortable adulthood the teen requi psychological permission from the isosexual parent. Inserti either sexual education or the provision of contracepti between the teen and the parent, or worse, sidelining the par all together, retards or stops the normal maturational proce

With parental consent 264 girls aged 15—17 volunteer to learn their fertility cycle. They were instructed in t Billings Ovulation Method, charted their mucus pattorns a reported any sexual relations, together with their procreat intention.

Personal growth of the study and control groups w monitored by means of human figure drawings and the Lo inger ego strength Scale. Details of the girl's performance reported:

1. In summary, ten percent of the girls were sexually active entry, five percent at the end of a one year study. Two thi (67%) of those enrolled continued to the end. There was "informed choice" pregnancy, and no method failures. T

pregnancies occurred three and five months after the two girls dropped out of the program.

2. A separate pilot probe among boarding school seniors undertaken **without parental involvement showed no change in the rate of sexual activity of 30%** from the beginning to the end of the six month term observation period.

3. The reduction of sexual activity in the study population is probably related to parental involvement, the educational program and perhaps of being in a study. The dynamics of the parent–daughter interactions can be summarized :

a. The parents were not hostile, but supportive.
b. Many felt that the program afforded a bridge for them to express their values and expectations about sexual behaviour to their children.
c. The group meetings provided a support for the parents.
d. We were invited to plan a similar program for their sons.

(Klaus H Int. Review, NFP Vol 8 '84, pp. 206–213).

What Teenagers Say about being aware of their fertility

1. A young teacher contacted us saying she thought she had gonorrhoea as she had noticed a profuse discharge during her cycle. She said she had never indulged in sexual intercourse and was most confused and worried. She was given a chart and the Ovulation Method (O.M.) was explained to her. As we had expected she produced a chart with typical ovulatory mucus and had observed both the ''Wet Sensation'' and the ''raw egg white' mucus. We assured her she was a most healthy fertile woman with no infection.

2. In another case at a working girls group the O.M. had been explained and charts given. The teacher reported that at a follow up session one jubilant girl produced a 3 month record of normal fertile ovulatory cycles. The teacher asked her why the ''terrific jubilation''? She reported ''You wouldn't understand. Two of my sisters are married and have no children. There is a boy who wants to marry me and he loves children. I thought maybe something is wrong with me and I would not say yes. Now I certainly can and will since I know I am fertile''.

3. Once we have explained the advantages of understanding and knowing the significance of one's moods, the variations during the cycle, the signs and significance of ovulation we have invariably found a new awareness of being a woman with a new found dignity and a challenge to regulate her fertility with and by her natural femininity when she is married.

''Love, Sex and Marriage go together''

CHAPTER 7

Contraception

"The purpose of this chapter is to inform NFP Teachers about all forms of artificial methods"

Classification of Methods of Family Planning

According to Mode of Action

— *Permanent or Irreversible Methods—Surgical Methods or Sterilisation.*

a) Male—Vasectomy
b) Female—Tubectomy

— *Temporary or Reversible Methods*

Behavioural Methods:

a) Coitus interruptus
b) Coitus reservatus

— *Natural or Physiological Method*

The Three Methods are :—

a) The Ovulation Method (Billings)
b) The Symptothermic Method.
c) The Basal Body Temperature Method.

— *Chemical Methods*

a) Foam Tablets
b) Spermicidal Jellies, foams, pastes and creams.
c) The Sponge or Douches.

— *Mechanical or Barrier Methods*

a) Condom or Nirodh
b) Diaphragm or Cervical cap

— *I.U.D. or Loop—Intrauterine Device*

— *Hormonal Methods*

a) Contraceptive Pill for Women
b) Contraceptive Pill for Men
c) Depo Provera—Injectable
d) Hormonal Implants for Women.

Behavioural Methods

Coitus Interruptus : As the name implies this is Coitu intercourse that is interrupted. Also called withdrawal Onanism).

Action : This is a Behavioural Method in which the Male withdraws his organ from the female vagina just before ejaculation.

Advantages : Inexpensive.

Disadvantages :

(1) Incomplete sexual pleasure.

(2) May fail when withdrawal is not done early enough or even when done because there is always semen with sperms at tip of penis.

(3) Psychologically frustrating to both partners, because of interruption.

Effectiveness : Difficult to estimate, but not high, about 30%.

Coitus Reservatus : Coitus that takes place normally but in which the male partner, by controlling himself, prevents ejaculation from occurring. Suitable for older couples. No moral bar to the use of this method.

Chemical Methods

These methods used by the female partner may be foam tablets, jellies, or cream which are placed in the vagina just before intercourse.

Action : These methods act by killing the sperms, hence called **Spermicidals.** They do not allow the sperms to live and travel to the tube to fertilize the ovum by the chemicals they contain.

The Foam Tablets : Are moistened with water and placed by the woman high up in the vagina, about 3–5 minutes before intercourse. They form a dense foam which traps and kills the sperms.

The Contraceptive Jellies or Creams : Are also spermicidal and used by the woman before intercourse. Aerosols are also used.

The Sponge : Called "Today" It is a cervical cap which besides blocking the cervix, releases spermicides and absorbs semen. Latest invention. Kept for 24 hours.

Advantages : None.

Disadvantages :

1. Either the man or the woman may develop an allergic reaction to the chemicals. This will necessitate in stopping their use. In addition, they should not be used in conjunction with NFP because they will confuse mucus observations and are less effective than NFP. Finally, there has been a recent report regarding the association of spermicides to the future development of **congenital abnormalities in unborn children conceived in women who have used spermicides.** This is a very serious problem which clearly requires public education. (2% congenital abnormalities in spermicidal users).
2. Expensive
3. Often fail because all the sperms may not be killed
4. Messy and unaesthetic
5. Many women dislike using them
6. Absorbed into the blood stream. Pass into milk and can harm the baby being breastfed. (I.C.M.R.)

Effectiveness : About 70%

Mechanical or Barrier Methods

Action : They act as a barrier and prevent the sperm from meeting the ovum.

(A) Diaphragm : Used by the woman, is first fitted by a doctor for assessing correct size. It is made of rubber with a spring rim and comes in 3 different sizes.

Method : Before coitus, the woman places the diaphragm in position. It is lubricated first with spermicidal cream and gently introduced into the vagina and fits on to the cervix, capping and closing the mouth of the cervix so that sperms cannot enter. It is removed 8-10 hours after coitus, washed and dried.

The diaphragm is designed to be used in conjunction with the spermicidal cream which kills the sperms.

Disadvantages

1. Diaphragms are messy and involves manipulation of the genitals. The woman is usually instructed to insert the diaphragm with the spermicide at least one hour before intercourse. In addition, after intercourse, the diaphragm must be left in place for 8 to 10 hours till the sperms are dead. The insertion of the diaphragm is an awkward job considered distasteful by many women.

2. The side-effects related to its use are an occasional allergy to the latex and/or to the spermicide.

3. In addition, **pelvic pain, cramps, urinary retent** bladder symptoms and/or aggravation of a recurrent bla or **urinary tract** infection may also be observed their use.

4. Sexual pleasure may be interfered with

5. Expensive (has to be replaced from time to time).

Effectiveness : Used by itself—about 50%
With Spermicidal Creams or Jelly 75%

(B) Condom or Nirodh : This is a contraceptive de made out of a thin rubber sheath to be used by the partner and worn on the erect penis preventing the spermat from gaining access to the cervix. Withdrawal is to be effe with care to prevent the condom from slipping off.

Upon ejaculation, the rubber sheath "catches" the sp in the pouch thus preventing them from getting to the egg. only a moderately effective method even if used correctly.

The biggest problem with condoms is that they are m and require the male to "be armed" before having intercou In addition, some men cannot retain an erection if a con is used and, either the man or the woman or both may hav allergic reaction to the rubber which is contained in condoms. For the NFP user, they will interfere with ma good mucus observations and they are less effective the natural methods.

The success rate is between 55-65%.

Advantages : (1) Also used to prevent S.T.D.—Sexually Transmitted Diseases

(2) Inexpensive.

Disadvantages :

(1) Interrupts coitus as it has to be put on after erection.

(2) May fail, because of a microscopic hole from which sperm will escape.

(3) Allergic reaction due to rubber or plastic.

(4) Interferes with sexual pleasure.

(5) Infection, (when condom reused in) wife.

Loop—Intra Uterine Contraceptive Device—I.U.D.

There are several different types of intrauterine devices currently on the market and some of which have been removed from the market.

The different types are depicted in Figure 16. All of the devices are made from a **polyethylene type of plastic** which contains **barium sulphate.** The barium sulphate is there so that the intrauterine device can be viewed on X-ray. The devices take on a variety of different shapes all of which have specific purposes in their "contraceptive" effect. In addition, some of the newer devices are copper-clad.

The **Copper-T** and the **Copper-7** are devices which have a copper wire surrounding their base. The **Progesterone-T** is a device which contains **slow releasing progesterone** in its core. The Dalkon Shield is a device which was removed from the market several years ago because of its adverse effects and associated deaths.

The I.U.D.'s work through many different actions which ultimately are uterus focused, preventing implantation of a newly fertilized ovum at about the blastocyst stage of development. There is little controversy at this time regarding the abortifacient action of the intrauterine device and yet many women are not informed of that action prior to having it inserted (Figure 16-3).

Method : The loop has to be inserted by a doctor who first examines the woman to rule out infection, tumours or early pregnancy. The correct size has to be chosen.

The loop has 2 nylon blue threads, which hang out in the vagina. By these the loop can be removed.

Advantages :

(1) Expensive for first insertion, as medical personnel and facilities needed.

(2) Once inserted maybe kept for years, so no motivation required. Should be replaced from time to time.

Disadvantages :

(1) Backache, discharge

(2) Bleeding can be severe

(3) Loop may perforate uterus

Effectiveness: About 75%

(An estimated 15,000 women per year are hospitalized with major complications in the U. S. A. from intrauterine devices.)

Side Effects

A. Severe dysmenorrhea
B. Heavy menstrual bleeding
C. Pelvic inflammatory disease
D. Perforation of the uterus
E. Spontaneous loss of the device
F. Infertility after removal

The biological effectiveness of intrauterine devices to prevent births is quite high but again the **continuation rate is very low**-about 70% at one year and 50% at two years. With such a high discontinuation rate the adjusted **pregnancy rate** has been estimated to be at 25 pregnancies per 100 woman years.

HORMONAL METHODS

Contraceptive Pill

Action: These substances which are known commonly as the 'PILL' are used to prevent pregnancy by inhibiting or suppressing ovulation, changing the cervical mucus and endometrial lining.

Method: In general the pills containing Oestrogen and Progestrone are given for 21 days starting on the 5th day of the Menstrual Cycle.

When taken for 21 days and followed by 7 days pa bleeding occurs, on the 5th day of which the pills are a started. Combined preparations in common use are LYND OVULEN, ANOVULAR, GYNOVULAR, etc. Sequential parations include Orthonovin, Serial 28 (with a 7 day plac of iron and vitamins).

Advantages and Effectiveness:

(1) When taken regularly the Pill is very effective (96-98 It ensures an anovular period after 7 days of therapy.
(2) Does not interfere with the act of coitus.

The Male Contraceptive Pills suppress spermatogene but are toxic and are not used generally.

It is not known exactly to what degree any of the oral c traceptives suppress ovulation. However, it is gener recognized that the higher the concentration of the estroge component the more likely is the pill to inhibit ovulati When the pills originally came on the market in 1960, t contained a higher dose of the oestrogen-like hormone t they do today. The reduction in oestrogen was to red the oestrogen-related side effects. Since this compon was largely responsible for the suppression of ovulati the newer pills do not suppress ovulation 100% of the ti Such lack of suppression may occur as often as **25 perc of the time**. Of the 41 combination birth control p currently on the market, at least 29 of them could classified as being in the "low dose estrogen" range.

Among the many concerns of the oral contraceptives, of the more important is their potential for being abortifaci

A. Common side effects or Disadvantages

1. Break-through or intermenstrual bleeding
2. Weight gain
3. Nausea and vomiting
4. Decreased menstrual flow
5. Creates a diabetic-like state
6. Affects over 130 metabolic processes in the body
7. Decreases sexual urge in women.

B. Other side effects (but very serious)

1. Thromboembolism
   a. Pulmonary embolus
   b. Myocardial infarct
   c. Cerebral embdus
2. Cervical cancer
3. Liver tumours
4. Gall bladder disease
5. Hypertension
6. Infertility

In addition to this, oral contraceptives given during the post-partum period may **interfere with lactation.** There may be a decrease in the quantity and the quality of the breast milk. Furthermore, the hormonal agents that are present in the oral contraceptives have been identified in the milk of the mothers who receive them. Specific effects on the child have not yet been determined, but are likely to be significant.

When the oral contraceptives are used properly, according to instruction, the biological effectiveness is high, probably in the 98 percent range. However, the **Continuation Rate** is extremely low. Hatcher indicates that during the first year of use only **45 to 70 percent of patients will continue** using birth control pills. With such a high drop-out rate, utilization of oral contraceptives has an estimated pregnancy rate of at least 25 per 100 woman-years of use.

Depoprovera or long acting injectables are banned in the U.S.A. because of their side effects. Hormonal implants are equally dangerous and should not be used.

Sterilisation or Surgical Measures for Contraception

(Permanent Method)

(A) Tubectomy in the Female : Is a permanent measure of contraception, done usually through an abdominal incision. Tubes are ligated and incised. Major operation in a woman, requires a trained surgeon. Vaginal sterilisation is done more rarely. (In Western countries, tubal clips and injections to block the tubes is done).

Effectiveness : 96-98%

Disadvantages :

(1) Recanalisation of the tubes is a remote possibility;

(2) Risks of major abdominal operation and anaesthesia present;

(3) Infection;

(4) Possibility of psychological problems;

(5) Menstrual disturbances;

(6) Ovarian dysfunction as blood supply to ovary interfered.

(B) Vasectomy : The tubes (Vas Deferens) in the male are cut and ligated through an incision in the scrotum.

Disadvantages :

(1) Permanent method. Reversibility cannot be guaranteed.

(2) Psychological effects ffrom nervous tension to impotence noted.

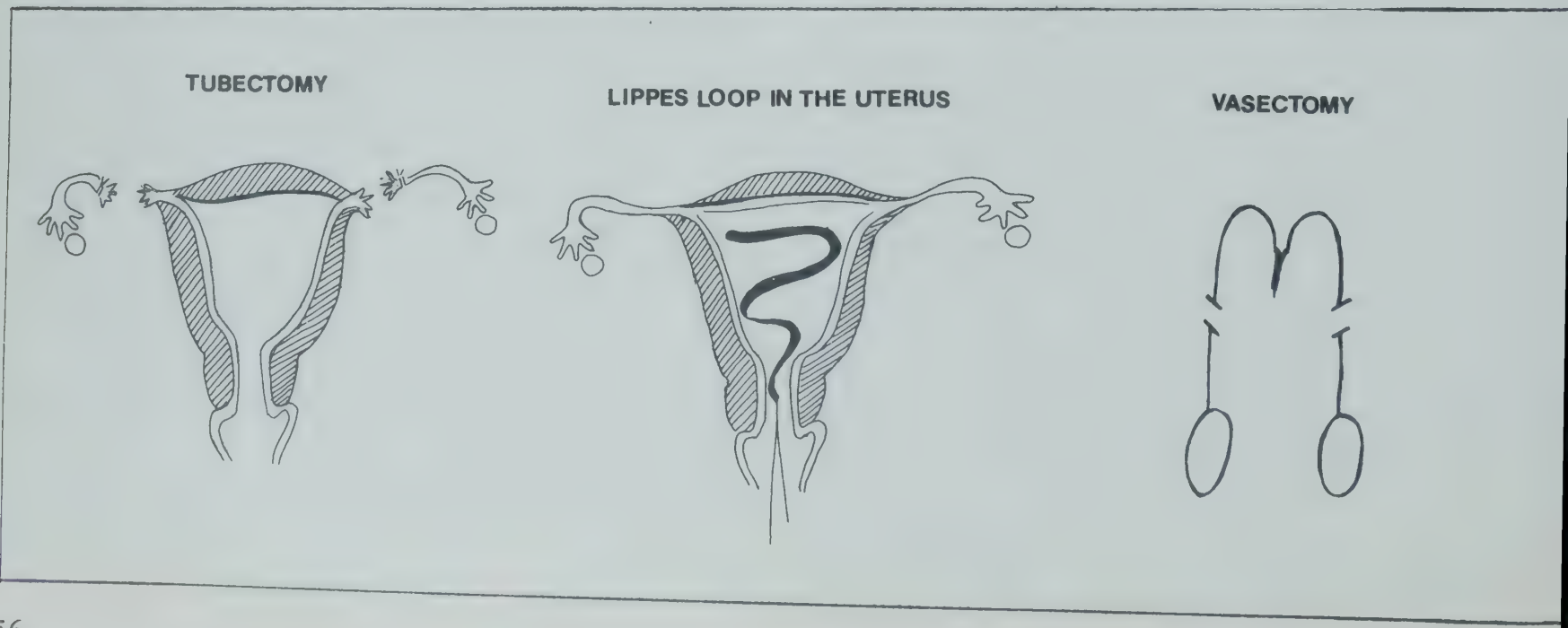
(3) Infection.

Effectiveness : 96-98%.

Laparoscopy

Occlusive procedures of the fallopian tube are carried out in a variety of different ways. The two procedures in addition to surgery used are **laparoscopy** or **mini-laparotomy**. In the first technique, the laparoscope (a lighted telescope-like instrument) is inserted below the umbilicus to directly view fallopian tubes. Then, with either hot cautery, or vari clipping procedures using inert materials, the fallopian tu are closed off by externally clipping them. Examples of would be the Hulka-clip (metal) and the Fallope ring. second procedure involves a small incision into the abdom cavity so that the fallopian tubes can be observed direc The tubes are then divided and ligated (Figure). Comp or partial removal of the fallopian tubes sometimes acc panies this procedure. All of these procedures occlude fallopian tubes thus preventing the egg from reaching the t to be fertilized by the sperm. The fate of the ovum is known.

Tubal ligation should be considered as a permanen sterilizing operation.



Men who have vasectomies are potentially fertile for about three months following the operation since sperms are present in the distal end of the tube. Many men who have had vasectomies but have been unwilling to totally let go of their fertility, have resorted to storing their own sperm in "sperm banks" for future use in case of a change of heart.

The complications of vasectomy are, for the most part, unknown. About 20 percent of men have feelings of incompetence following vasectomy. Studies are currently in process to determine what effects permanent blockage of semen will have. Some studies have indicated that antibody production which results from the backflow of sperm may result in such things as arthritis or even arteriosclerosis, or hormonal imbalances leading to hypertension etc., etc.

(For side effects and complications of contraceptives and sterilisation refer "Monograph" from Crest).

CHAPTER 8

Problem Cases - Guide to NFP Use

I. MARITAL PROBLEMS & NFP

If there is a problem in NFP usage, this is a symptom of a deeper marital problem, and it may be possible that you can help the couple with both the problems.

Principles of facilitating interpersonal relationships :—

For the NFP Teacher

a) Treat the problem of the relationship as their problem. The focus should be on their marriage relationship in case of marriage problems.

b) Never take sides for if you do it will harm the counselling process and the couple will lose confidence in you.

c) Help them to talk to each other and not to you or through you. I sometimes say "I believe it will be more helpful if you looked at him or her and say these things directly to him or her".

d) Help them to listen to each other. Not only to the words but to their feelings as well. It helps sometimes to stop the conversation and ask either or both of them to repe what the other person said, both words and feelings.

e) If multiple issues come up help them to deal with or thing at a time. Talk about the method, the chartin abstinence etc. clearly and elicit both husband and wife response.

f) Make it clear to yourself and to them that in any marriag **conflicts are inevitable,** but that it is important to wor through them by honest communications with each othe But dealing with one conflict in your presence, they migh learn to analyse the nature of their relationships and get a insight into their present problems and future possibilitie

g) I find that focussing on the individual and family **strength** is very helpful. Making new discoveries of their unuse potentials and abilities inherent in them give the confidence and hope.

h) It takes motivation, hard work and time for healing an growth to occur. If you find one or both persons involve unable to respond to the above, referral may be considere (It helps to know and have working relationships with

physician and some mental health professionals in your community for clearing up doubts etc). If the husband is an alcoholic the problems are only secondary to the main problem of alcoholism which must be tackled seriously.

II. AFTER THE PILL & NFP

What to expect after stopping the Pill?

Within a few days of discontinuing the Pill, you will bleed as you normally do after each cycle of the Pill (withdrawal bleed). This is due to the sudden removal of the Pill's synthetic hormones. The lining of the uterus grows in response to the synthetic hormones and is usually shed when these are discontinued.

The next time you bleed may be about one month later. However, not all women menstruate so soon. Typically studies have found that after the initial withdrawal bleed, 30 per cent of women coming off the Pill menstruate within thirty days, a further 60 per cent menstruate within sixty days, another 8 per cent menstruate within two to six months, and 2 per cent do not menstruate until after six months.

There is no way of predicting how long it will take an individual woman's body to return to normal, and for her natural ovulatory cycles to resume. For most women ovulation usually returns after a few cycles. Some may ovulate in the first cycle after stopping the Pill: so it is necessary to be watchful for signs of fertility this first month.

Prolonged delays in ovulating occur most commonly among young women using the Pill, and those prone to irregular periods before starting to take the Pill. Although this anovulatory situation is not a threat to health, it makes conception impossible, and suggests a significant metabolic disturbance. Treatment with fertility drugs is often successful in re-starting ovulation and menstruation, and about 50 per cent of women conceive after treatment. It is wise to allow at least twelve months for the natural cycles to resume before contemplating fertility drugs.

The Mucus after coming off the Pill

The type of Pill you have been using will affect the mucus pattern that you now see. It is most likely that during the first month of charting you will recognise a mucus pattern that indicates infertility.

This infertile pattern will be one or two types. Either you will see no mucus, and experience dryness, or you will have an *unchanging mucus that is sticky and scant*, or continuous and wet and that looks milky or watery. Different women have their own ways of describing this infertile mucus; however a characteristic they always notice its unchanging nature.

Some women experience a wet discharge that varies significantly from day to day. In such circumstances it is advisable to have a medical examination as this type of mucus may be caused by a damaged cervix, requiring treatment.

The first ovulation after coming off the Pill

Initially, the body may make several attempts to ovulate, and these are recognisable by a change in mucus. The hormone levels may rise and fall again without reaching the level

necessary for ovulation. Each rise is associated with a mucus change.

The change may take the form of an altered mucus sensation or appearance, or the occurrence of spotty bleeding. You will know you have not ovulated because of the failure to menstruate within ten to sixteen days of such changes.

Because any of these changes could lead to ovulation, it is important to observe carefully. Often the first ovulation after coming off the Pill is accompanied by abdominal pain, severe in some women. However, pain is an unreliable indicator of ovulation, and should not be allowed to contradict your mucus signals.

As you become more aware of your individual mucus pattern, the infertile mucus — whether flaky, sticky, cloudy or wet, and the same day after day — can be distinguished from any mucus that is different. Recognition of the initial infertile pattern, and avoidance of intercourse during — and for three days after — a change in the pattern, will enable you to see your fertility return without conceiving.

Most women using the O. M. for the first time after taking the pill will need a few normal cycles to be able to recognise confidently the Peak of fertility.

Naturally it is helpful when learning the method to talk with other women who successfully use it.

III THE OVULATION METHOD IN THE PRE-MENOPAUSE

The O. M. of fertility control can provide security during this time of changing fertility.

If a woman has not used the O.M. before, this need n prove an obstacle.

It is not necessary to predict the end of fertility : the key successful fertility regulation at this stage is positive recog tion of the infertility which will eventually become absolute.

A woman can recognise whether she is fertile or infert from her cervical mucus. If any difficulties arise, a teach of the method, or another woman who has successfu used the method, will be able to help her through this tir of irregularity.

A woman says —

"At forty-five, with my cycles becoming increasingly lon and irregular, my life seemed to be turning into a monstrou game of roulette. Would a chance pregnancy result from a occasional act of love-making ? I wondered anxiously.

My doctor cheerfully told me that I couldn't conceive eve if I tried. But when I consulted another doctor he advise the pill.

When I heard about the O.M. I did not think I could us it because of the lack of any apparent mucus patter I could recall mucus resembling raw egg-white occurrin perhaps two years ago, but certainly not in recent times.

By keeping a careful record for the next four weeks an by being alert to my mucus subsequently, I knew that I wa infertile. This knowledge has given me a new peace of min and release from unnecessary abstinence".

Events leading to the menopause

The decline of fertility usually occurs gradually as the functions of the ovaries and cervix change. Most available eggs have matured and left the ovary and although the lining of the uterus may continue to build up and break away and menstruation may continue for months or years due to fluctuating hormone levels, ovulation is occurring less and less frequently.

Statistically, once you reach middle age you are in an age group of low fertility. Studies show that between the age of forty-five and fifty years, only one woman in 700 is able to become pregnant; and after the age of fifty, the figure drops to about one in 25,000.

The Mucus during the Menopause

You may experience dry days for weeks or months, or scanty amounts of dense mucus which does not change. Typically, the pre-menopausal mucus pattern indicates infertility by remaining unchanged day after day.

In some women the mucus is sparse or non-existent, producing a dry sensation, or it may be crumbly, cloudy, yellow, flaky or clotty, or even watery and continuous, without ever developing the lubricative qualities of fertile-type mucus. Every woman experiences an individual pattern of infertility which she can learn to recognise.

It is common for dry days to increase in number, and for whole cycles or months to pass during which no mucus is seen or felt. Any return of possible fertility will be mirrored by your mucus. If you are fertile, the fertile type mucus will be evident by the sensation it produces and your observations of it.

IV. BREAST FEEDING & NFP

Edward F. Keefe writes, "We face the paradox of a decline in breast-feeding, both in incidence and duration, in developing nations just when its importance is being recognized in the more advanced nations. Essential to family planning and in harmony with nature are moves to encourage breast feeding and to reverse trends away from it. Breast-feeding means unlimited suckling by the infant not just a dose of milk for fifteen minutes four or five times a day.

Most of those concerned about world population seem not to realize that in the world as a whole the PRINCIPAL FACTOR IN CHILD-SPACING IS LACTATION, more effective in the developing countries than all the efforts of family-planning professionals with their pills and devices.

In this century many of the people of the West have come to view "bottle-feeding" as the way of feeding, and contraception has then become a part of life. Natural lactation is looked at as really unnecessary, low class, and for most women impossible. The loss of the natural spacing of pregnancies that breast-feeding brings about has led to the feeling that contraception is a necessity.

What causes this Infertility during the Breastfeeding period ?

Oestrogens are at a low level while you are breastfeeding This is due to the effect of the hormone, prolactin, which controls breast milk production.

As time goes by, the pituitary gland at the base of the brain starts to switch off prolactin production. Gradually the hormone cycle leading to ovulation takes over. This may occur in a series of stop/start events, as if the body is trying to ovulate. You can see these hormone fluctuations reflected in changes in your mucus. Do not presume the first bleeding you see is menstruation. Light bleeding or spotting may be due to a rise in oestrogens coinciding with ovulation and a return of fertility. Avoid intercourse on all wet days and for three days after the last wet day.

BREAST FEEDING AND FERTILITY

Summary and Conclusions

1. Breast feeding does delay the return of both menstruation and ovulation.
2. The longer one fully breast feeds, the more unlikely both menstruation and ovulation are likely to occur.
3. About 50% of women who breast feed regardless of duration will not resume menstruation until weaning or the cessation of breast-feeding.
4. The return of ovulation in fully breast–feeding mothers will not occur (with high degree of probability) before 16 weeks post-partum.
5. However, when ovulation does recur, in fully breast feeding women, a high percentage will recur before the 1st menstruation (37.7%). There appears to be no difference in this fact between lactating and non–lactating women.
6. The overwhelming majority of pregnancies that occur during breast–feeding occur during weaning.
7. Primiparas and women less than 25 years of age appear to be able to suppress ovulation through lactation more effectively than multiparas or women 25 years of age older.
8. Full breast–feeding and no supplementary (anything) d appear to provide a high degree of protection fr pregnancy, but only in the 1st 8–10 weeks post partur

Return of Menses

I. *POST PARTUM BY METHOD OF INFANT FEEDING:*

Method at 4 months :		% Menstruati
Only Breast	–	39.8
Breast and Artificial	–	56.8
Artificial only	–	95.3

(McKeown et al J. Obst./Gynaecology – 1954)

II. *CONCEPTION BY METHOD OF INFANT FEEDING :*

Method		No. of Case
Breast only (1)	–	2
Breast and Artificial (2)	–	6
Artificial only	–	79

1. Had one menses before conception
2. Had no menses before conception

(McKeown Ref. "The Picture Dictionary of the O.M." "The O.M. of Natural Family Planning" & Reproc Anatomy & Physiology for the NFP Practitioner B Hilgers).

RETURN OF FERTILITY AFTER CHILDBIRTH – A GUIDE

	Prolonged total breastfeeding	*Brief period of breastfeeding (less than one month)*	*No Breastfeeding*
First Menstruation	may occur before weaning usually after weaning sometimes up to 6 weeks after the end of weaning consult your doctor if delayed more than 6 weeks	usually occurs after 6 or 7 weeks occasionally later consult your doctor if delayed more than 10 weeks	usually occurs after 6 or 7 weeks occasionally between 8th to 10th week consult your doctor if delayed more than 10 weeks
First Ovulation	never occurs before the 6th week **rarely during total breastfeeding if menstruation hasn't returned** often at weaning occasionally 2–4 weeks after weaning	never occurs before the 5th week often during the 2nd month– rarely after 3 months	never occurs before the 3rd week usually between 6th to 8th week before first menstruation in 50% of women
Rhythm of cycles is re-established	quickly and reliably after first menstruation	quickly and reliably after first menstruation	progressively from 1–3 cycles after first menstruation.
Infertility	during the first 5 weeks after childbirth	during the 4 weeks after childbirth	during the first 3 weeks after childbirth

	Prolonged total breastfeeding	*Brief period of breastfeeding (less than one month)*	*No Breastfeeding*
Infertility still highly	during the 6th to 10th week if breastfeeding is TOTAL and if menstruation hasn't returned.		during the 4th week wit 99.8% probability
Possible Infertility	up to the end of total breast feeding (at least to beginning of weaning) for women with previous breastfeeding experience		
Conception Possible	as early as the 6th week especially if breastfeeding is no longer total or if menstruation has returned	as early as the 5th week even if menstruation hasn't returned	rarely (0.2%) during the 3r week, then with increasin probability even if menstrua tion hasn't returned
Keeping an OM Chart Advised	from the 5th week on	from the 4th week on	from the 3rd week on

(*Ref :* "Serena", Canada Publication)

"Breast Feeding is the best feeding"

CHAPTER 9

Population Education

"Population is People. Take care of the people and the population will take care of itself."

1. Population education is the arousing of the awareness of the impact of population dynamics on the people.

2. It's aim is to inculcate, in youth particularly, principles of responsible parenthood.

   Youth are the population decision makers. An understanding of their role, its importance and the development of healthy attitudes are essential.

3. This is the aim of Population Education which should be combined with Family Life Education which is defined as an education in values and relationships with the aim of developing a sound system of values and acquiring the skills to acquire and maintain healthy and satisfying relationships.

Statistics	*Latest available figures 1981*
Area of India	32,87,782 sq km
Total population	683,810,051
Population Growth Rate	1.8 percent
Population Birth Rate	32.9 percent (in 1978-79)
Population Death Rate	14.7 percent
Infant Mortality Rate	129 per 1000
Women of fertile age (15-44)	117,651,000 (in 1970)
Population under 15 years	42 percent
Urban population	24 percent
Rural population	76 percent
GNP per capita	110 US dollars (in 1970)
Population per doctor	3,730 (in 1978)
Population per hospital bed	1,671 (in 1965)

The **Birth Rate** is being lowered. The **Death Rate** has plunged and the difference between the two rates which is the **Growth Rate** is nearly 2 percent. India accounts for 15 percent of the world population and 21 percent of the developing world, and has only 2.4 percent of the worlds land area.

4. In 1941–51 decade, the annual increase in population was 4 million which increased to 8 million in 1951–61, to 14 million in 1961–71 and to 14 million in 1971–81 decade. Thus the annual additions to our population have more than trebled in the last 30 years.

5. Additional resources required for an annual increase of 14 million in the populations are :

Foodgrams	: 11,850,000 qtl.	Cloth	: 180,000,000 mtr.
Schools	: 121,000	Teachers	: 355,000
Houses	: 2,391,000	Jobs	: 3,813,000

6. The direct cost of maintaining the additional 14 million population at an average income level of Rs. 1,000 per year per person comes to the huge amount of Rs. 1,400 crores.

7. Out of the total population of 683.8 million in India, 353.3 million are males and 330.5 million are females.

8. For every 1,000 males we have 935 females.

9. The total area of India is 3.39 million sq. km.

10. The density (number of persons per sq. km.) of population in India is 221.

(For detailed information/references on Population read "Population Education for Quality of Life" Oxford & India Book House by M.M. Mascarenhas).

REASONS FOR HIGH BIRTH RATE AND LOW DEATH RATE

1. Universality of marriage
2. Children an economic asset
3. Early age for marriage especially in rural areas
4. Male Sex preference
5. High infant/child mortality urge to balance loss
6. Religious and social prestige
7. Social security in old age.

1. Improved Health Facilities
2. Immunization against smallpox, cholera, plague, typhoid, tuberculosis. Therefore decreased deaths
3. No famine or pandem
4. No wars
5. Improved sanitation & health education.

Population Control is Effected by various ways

1. **Education,** especially of women. (Total literacy rate percent in India. For women this is 18 percent and rural areas only 9 percent).
2. Enforcing the raised age of marriage (legal age of marria is 18 for girls and 21 for boys. This is not prope enforced).
3. Family Planning information and usage.
4. Modernisation of agriculture.
5. Old age pension and security benefits.
6. Preparation for Marriage and responsible Parenthood Schools, Colleges and Welfare Centres.
7. Raised standard of living for those below the poverty li for a total development of man.
8. Lowering the Infant Mortality Rate.

Population Explosion is the term used to explain the growth of population which outstrips the growth of resources. The situation is therefore explosive and violence, hunger, unemployment, poverty and illiteracy result.

Population Dynamics refers to the changes in population, due to Birth Rate, Death Rate and Migration and other factors which directly affect Population.

Wholistic Health

"Caring for the physical life of persons is a basic need. In providing ever more adequate attention to the physical life of others and of ourselves, we can draw upon the growing resources of a wide range of health care specialists. A contemporary movement known as wholistic health gives promise of integrating disease elimination or healing activity with health enhancement or wellness programs.

However much we may disagree about the values placed upon various therapies and health maintenance measures, we can agree on the critical need to develop a consistent commitment to a harmonious set of physical health values. A similar need and variety of means presents itself in the search for mental and emotional health. The need and means for promoting psychic wellbeing are less tangible but just as real as those in physical health care. The twentieth century is the age of systematic psychology.

Spiritual and religious health care is another primary point of attention for authentic persons. The true and the good of ultimate meaning and value in our lives warrants our keenest concerns." (Robert E. Joyce).

Some Cultural Considerations

Basically, the majority of Indians irrespective of caste or religion have been indoctrinated to practise abstinence of various kinds, for example, fasting for religious or social reasons, abstinence from sleep, abstinence from speech, sexual abstinence during Ramzan (Muslims) and Adimasam (South-Indians). "Aadi" month, approximately July 15 to August 15 is the time when "Viradham" or abstinence from intercourse is observed in order to avert the birth of children the following summer, when infant mortality due to dehydration is high. This practice is followed extensively in Tamilnadu and Andhra Pradesh in South India.

Smt. C. Sharada (Social Welfare Board) says specifically- "Our ancient rishis and munis gave high priority to Brahmacharya and there are many people in India who are practising it even now. Self Control and Indriya Nigraha are methods which have been used over the ages and there is no reason why in our anxiety to make use of modern science we should neglect these methods. The motivational media should make use of this aspect to the maximum extent," **Smt. Radha Bhatt** remarks, "It was the custom to marry girls when they were young. But they stayed with their parents till they reached puberty. The consummation of the marriage took place on the 15th or 16th day after the first day of menstruation.

This function was an elaborate one with a lot of ritual. The ritual was termed as Garbhadana or Shobnaprastha. The girl or the boy would be advised by the priest to cohabit on that day at a specific time. So even in ancient India the existence of the fertile period was known and used."

Tribals and other people have for centuries believed that around the "red period" (menstruation) intercourse does not result in pregnancy, whereas in the "white period" (mucus) it does.

NO IDEAL CONTRACEPTIVE

"We have to accept the fact that at the moment there is no ideal contraceptive free from side effects and complications suitable for use in all women. Nor is any such method likely to emerge during the foreseeable future. We do, however, have a variety of methods from which the most appropriate method for any couple can be chosen.

The resources of the nation and individual, the socio-cultural milieu, health status, health care delivery systems and needs of the individual should all be taken into consideration for choosing the appropriate contraceptive method."

(Ref: I.C.M.R. Bulletin, Vol. II No. 12 Dec. '81, New Delhi).

NFP and Maternal & Child Health

NFP is especially indicated in couples where the risk of maternal or infant death is high and in a few other cases

1. For delaying the first pregnancy
2. Pregnancies before the age of 20
3. Pregnancies after the age of 35 and in between
4. Pregnancies less than 2 years apart
5. To plan a family in consanguinous or where a his of a congenital/hereditary defect exists, since in course on "peak day" can minimise defects.

Child Care Education

1. Breast feed as long as possible
2. Introduce semi–solid food at 5–6 months
3. Feed young children five to six times a day
4. Don't reduce food in illness
5. Use the health services available
6. Get children immunized
7. Keep yourself and your surroundings clean
8. Drink clean boiled water.

Community Health & NFP

The need to make the community **aware** that each cou hold the key to fertility regulation is vital to the populati programme.

1. *Awareness :* By information, talks, literature and audi visual means is essential to achieve this awareness.
2. *Attitude :* In the community, hospitals and health a social welfare centres, health and medical personnel shou have a positive attitude to natural methods of fam planning. They should be ready to train their staff who turn will supervise **"barefoot teachers"** of the comm nity. These are women or couples who will propag and use the method themselves.

"A Couple using the Method for Spacing"

3. *Acceptance :* The Stage of acceptance by the people is important and will come only after attitudes change. It is vital to have a voluntary acceptance of family planning motivated by welfare of both child, mother's health and family happiness.

4. *Action :* Once having decided to accept NFP, couples and women must be instructed, followed up and motivated to continue for spacing or limitation.

5. *Accessibility :* The NFP Teacher must support the n acceptors by being accessible. Charts, marking pen and teaching aids must be easily available. Any proble encountered in the cause of using NFP must be dealt wi

The infrastructure must be firm and extend into areas marriage preparation; maternal health and postnatal care a have good liaison with other health, medical, and soc services.

Motivation. The couple should be motivated to continue using NFP by good follow up by the teacher. Initial difficulties if overcome by sound advice will make for successful use and a high degree of effectiveness.

CHAPTER 10

Sample Records and Evaluation

APPENDIX A

INDIVIDUAL CASE RECORD—CONFIDENTIAL

Centre *Teacher* *Serial No.*

Date *Registered since*

Name *User since*

Detailed Address

Age *Autonomous couple*

Religion *Education*

Date of birth *Income*

Youngest child *No. of Children*

Miscarriage/Abortion (Dates)

Previous methods used *Medical Problems*

Attitudes to Family Planning—Wife's. *Husband's—*

Methods being used Pill, Loop, Rhythm, Nirodh, Cap, C. I. Others

With dates

Cause of any Failure *Pregnancies* 1) Planned 2) Unplanned

User Failure Method Failure

(To be filled up only for Registered Couples)

Please use the reverse for all follow up visits. Enter the date, progress, any comments every fortnight/month.

APPENDIX—B

TEACHER'S FOLLOW-UP VISIT CHECKLIST FOR COUPLE

	Date	Date	Date	Date	Date	Date
NAME						
DATE						
DAYS : Mucus/Wetness/dampness						
Days of Maximum secretion						
Days of Peak						
Other signs/symptoms of Ovulation						
Specify Mucus after Peak ..... (If any mucus following and continuous with the **Peak** please make note separately)						
Any disturbance recorded						
No. of Acts I.C. recorded						
Any genital contact infertile phase						
Average frequency I.C./Week						
Observed Rules?						
If not — Reason						
Husband's Attitude						
Cooperative						
Indifferent ...						
Uncooperative						
Hostile						
Subject intends to continue						
PROBLEMS						
TEACHER'S REMARKS						

APPENDIX–C

NFP TEACHER'S TEST–TECHNICAL ASPECTS

If Literate write answers. If illiterate an oral test will be satisfactory.

1. Name the sex hormones in a woman.
2. Name the sex hormones in a man.
3. Name the reproductive organs in a woman.
4. Name the reproductive organs in a man.
5. What is the function of the ovary?
6. What is the function of the testis?
7. Does India have a population problem? Why?
8. Why should a couple plan their family?
9. In India, What is the Birth Rate?
   What is the Death Rate?
   What is the Growth Rate?
   What is the Infant Mortality Rate?
10. What are the natural methods of family planning?
11. What are the symptoms and signs of Ovulation?
12. Why does Temperature rise?
13. Is there Ovulation during pregnancy?

14. What is menarche? What is menopause?

15. What is semen? How long does the sperm live?

16. What is mucus? What is its function?

17. What is the interval between Ovulation and Menstruation?

18. What is the interval between Menstruation and Ovulation?

19. Does periodic abstinence harm a man?

20. Does periodic abstinence harm a woman?

21. What are the advantages of the NFP ?

22. What are the disadvantages of the NFP?

23. Can Natural Family Planning be used by all couples?

24. What is the "built in indicator" of Ovulation?

25. What is Leucorrhoea? How would you deal with such a case?

CONTRACEPTION

I. Identify, by means of the corresponding letter, the principal mode of action of the following contraceptives. The sam answer can to be used twice.

(1) Condom ( )
(2) Diaphram ( )
(3) Combined pill ( )
(4) Chemical contraceptives ( )

(a) blocks the opening of the cervix
(b) collects the sperm at the ejaculation
(c) destroys spermatozoa
(d) suppresses ovulation
(e) alters the uterine lining

II. Identify, by means of the corresponding letter, the advantage one can associate with each of the following contraceptives.

The same answer cannot be used twice.

(1)	Intra-uterine device (IUD)	( )	(a) cannot fail
(2)	Pill	( )	(b) simple to use
(3)	Condom	( )	(c) very effective
(4)	Natural Family Planning	( )	(d) can be ignored sometimes.
			(e) self-knowledge and very effective

III. Identify, by means of the corresponding letter, a disadvantage often associated with the following contraceptives.

(1)	Sterilization	( )	(a) backache, bleeding, abdominal pains
(2)	Pill	( )	(b) handling of the genital organs
(3)	I.U.D.	( )	(c) some side effects such as nausea, headache, irritability
(4)	Diaphragm	( )	(d) irreversible
			(e) interferes with spontaneous love making.

IV. Why is it difficult for a woman to use the O. M. when contracepted by:

1) I U D ..... 2) Diaphragm ..... 3) Condom .....

4) Pill ..... 5) Spermicides.....

OVULATION METHOD TEST

A) The Method in General

1. How does it suit the woman with long cycles?

2. Is it suitable for every couple?

3. What the are requirements for the successful use of the O. M. ?

4. What is the husband's role when a couple use the O. M. ?

5. Should husbands attend the teaching session ? Why ?

6. How is the method best taught ?

B. Mucus and Fertility:

1) Where does the Mucus come from ?

2) How does a woman know that she has a secretion ?

3) What causes the Mucus secretion ?

4) What are the signs in the Mucus which indicate fertility ?

5) What is the "PEAK" day of fertility ?

6) What are other types of secretion ?

7) What is the significance of spotting ?

8) How would you advise such a woman ?

9) Has every woman the same pattern of fertilite type mucus secretion ?

10) Can a woman have a very watery secretion and see no obvious mucus ?

b) How would you advise such a woman ?

11) How does a woman know that she has not ovulated ?

12) How would you help a nervous couple to gain confidence in the Ovulation Method ?

13) If you have a chart you can't handle how would you go about referal ?

14) What time of the day is the best time for the woman to record her symptoms on chart ?

C. Ovulation:

1. How many ovulation days are there in a cycle ?
2. When does ovulation occur in relation to the next period ?
3. Can there be more than one ovulation in a cycle ? When ?
4. What effect has stress, grief, operations, or change of environment on ovulation ?

   d) How would you advise such a woman ?

D. Summary:

1. Describe in your own works the various stage in an ordinary table menstrual cycle.
2. Does a woman need to observe her sensation in the genital area every day ? Why ?
3. Why should the couple avoid sexual contact or coitus interruptus during the fertile time ?
4. What rules apply: (give reasons)

   a) Mornings of early days ?
   b) During the period ?
   c) Dry days prior to ovulation ?
   d) Days of mucus secretion ?
   e) 3 days after Peak ?
   f) Missed periods ?
   g) Spotting of intermenstrual bleeding ?
   h) Spotting followed by mucus ?
   i) Patches of mucus ?

(For key to test write to CREST, 14 High Street, Bangalore-560 005)

APPENDIX D

TEACHERS' LIST OF USER COUPLES

O.M.-Natural Family Planning Statistics

Sl. No.	Code	Name	Month Started	Autonomous	Month Disc	Reason Disc U.F./M.F.	Remarks
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

PLEASE READ CAREFULLY

N.B.: This statistics sheet is a very useful one for data collection

CODE—Code of teacher Eg. If full name is Leela David—Code is L.D.

MONTH STARTED—Refers to month in which charting commenced. Hence if in July 1985 it will be 7/85.

AUTONOMOUS—Refers to a couple who are successfully following the O.M. for 6 to 9 months and do not require supervision.

REASON DISC—Refers to U.F. or User Failure and M.F. or Method Failure.

REMARKS—like planned pregnancy, will return to method or shifted to other methods etc.

APPENDIX—E

NFP REFRESHER COURSE PART I

1. Each participant describes briefly his/her job involvement and the factors that have enhanced or hindered the work.

2. Each participant outlines any plans for his/her future work.

3. **In your NFP Project/Work do you have adequate** —

   (a) Participation by the People in the project work ?

   (b) Involvement by the Individual couples for motivation to become Teachers themselves ?

4. **Threshold of Acceptance by the Community**—Have you been able to gauge the threshold or point at which couples/ women will come for advice to practise NFP.

   (i) People must be aware that NFP advice is good and useful to them
   Awareness—Motivation—Acceptance.

   (ii) They must accept it as necessary for them now or at some later stage. This makes for a positive attitude.

   (iii) NFP help must be easily accessible for them.

REFRESHER COURSE PART II

Teacher's Evaluation

1. Why am I working ?

2. What are my objectives ?

3. Who am I serving ?

4. Of what value is the service I am giving ?

5. Does it meet a need of those who come to me ?

6. Do I feel any responsibility and concern for those whom I serve ?

7. Do I need to re-think, re-plan, change the pattern of service ?

8. Am I involving the right people to help in the programme ?

9. Has the community been able to share in the work ?

10. Have I trained someone to take over my responsibilities in time of emergency ?

N.B. - The above should be done as a sharing when teachers meet or individually, or at the Refresher Course.

The teacher should constantly evaluate herself. It helps her to see new insights into her failures, the rea for her successes, and gives her confidence to continue with a wider vision of service.

REFRESHER COURSE PART III

Revise all previous Chapters
Retest
Check Charts
Oral Test on Problem Cases
Check own Chart

CHARTING INSTRUCTIONS

The Ovulation Method (O.M.) of Family Planning

The O.M. is a natural method of F.P. (N.F.P.). It is based on the scientific fact that a woman can only become pregnant when she is in her fertile period.

She can identify this fertile period easily, by **certain signs** caused by the rise of female oestrogen (sex hormone) in her blood only at this time. **She does not need to be educated or have regular periods to use this method effectively.**

These signs are :

1. **Mucus** secretion from the cervical glands in the uterus (womb). This is **felt** as a **wet sensation** in the genital area.
2. The mucus maybe also **seen** as a raw egg-white discharge at this time.
3. There is **pain** in the abdomen on the side which releases the ovum (i.e. Right Ovary or Left Ovary). This is felt as a sharp pain, or backache often going down the thigh.
4. The Breast feels heavy, and there maybe a dull pain.
5. There maybe a little bleeding or brownish discharge called spotting.
6. There maybe mood changes. **The strongest sign is the mucus.**

Charting to detect your fertile period

Mark your chart daily at night. Colour red in the square on the days you menstruate.

Menstruation is usually followed by days of dryness. When the cervical glands begin to get stimulated by oestrogen they discharge a thick white secretion which marks the beginning of the fertile period and the woman begins to feel wet. Then it becomes thin and translucent (egg-white).

The wetness is a warning sign to the woman who wants to use the O.M. for F.P. She stops all genital contact with her husband. She abstains for all these **wet days** or when ever she sees the secretion. The last **wet** day is called the **Peak Day** and it is followed by Ovulation i.e. **Day 1.**

The ovum may live upto 18 hours so she abstains on **Day 2**, and on **Day 3** for safety. By this time she becomes infertile and can resume intercourse. (The sperm or male egg can live upto 2 days in mucus rarely longer).

Start charting immediately in the square corresponding to the day of your cycle. For e.g. the first day of your menstrual period is Square 1. When you start a new cycle mark in this square **(1)** and write the date. Show your chart to a NFP Teacher.

Mark Blue for **dry days** when **nothing** is felt. Mark O circle with a dot (sign of ovum) for wet days. Mark an X on Peak Day which you will only known on Day 1. Mark in 2 and 3 on the following 2 days.

This Natural Family Planning (NFP) method is safe, effective and acceptable to all couples.

Queries to CREST, 14 High Street, Bangalore 560 005. Copies of the book could also be had from them or from the publishers : Asian Trading Corporation, 150, Brigade Road, Bangalore-560 025.

PLAN YOUR FAMILY THE NATURAL WAY

To live with our bodies, and not in spite of them, is a discovery our "Civilized" world is just now making. An old Asian Wisdom maintains that perfection is only acquired through the mastery of the body. The more one is able to live with his or her own body and master its nature, the freer is one's mind and the wider the horizons. An African chief told me recently, when describing the period of abstinence required for couples in his tribe after the birth of a child (sometimes until the baby can walk or even longer), **"A real man is one who can wait. Only a child takes what he wants when he wants it!"**

Ingrid Trobisch